University of Alberta

Empowerment and Autonomy Among Continuing Care Nurses/Residents

by

Andrea Turnbull

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfillment of the requirements for the degree of Master of Nursing

Faculty of Nursing

Edmonton, Alberta

Spring 2001

National Library of Canada
Acquisitions and Bibliographic Services
395 Wellington Street
Ottawa ON K1A 0N4
Canada

Bibliothèque nationale du Canada
Acquisitions et services bibliographiques
395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence

Our file Notre référence

The author has granted a non-exclusive licence allowing the National Library of Canada to reproduce, loan, distribute or sell copies of this thesis in microform, paper or electronic formats.

L'auteur a accordé une licence non exclusive permettant à la Bibliothèque nationale du Canada de reproduire, prêter, distribuer ou vendre des copies de cette thèse sous la forme de microfiche/film, de reproduction sur papier ou sur format électronique.

The author retains ownership of the copyright in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

L'auteur conserve la propriété du droit d'auteur qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

0-612-60405-5

Canada

University of Alberta

Library Release Form

Name of Author:	Andrea Turnbull
Title of Thesis:	**Empowerment and Autonomy Among Continuing Care Nurses/Residents**
Degree:	Master of Nursing
Year This Degree Granted:	2001

Permission is hereby granted to the University of Alberta Library to reproduce single copies of this thesis and to lend or sell such copies for private, scholarly, or scientific research purposes only.

The author reserves all other publication and other rights in association with the copyright in the thesis, and except as hereinbefore provided, neither the thesis nor any substantial portion thereof may be printed or otherwise reproduced in any material form whatever without the author's prior written permission.

Andrea Turnbull

69 Arcand Drive
St. Albert, AB
T8N 5V8

April 12, 2001

University of Alberta

Faculty of Graduate Studies and Research

The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled **Empowerment and Autonomy Among Continuing Care Nurses/Residents,** submitted by Andrea Turnbull in partial fulfillment of the requirements for the degree of Master of Nursing.

Professor Donna Lynn Smith, Supervisor

Dr. Phyllis Giovannetti

Dr. Pauline Paul

Dr. Sharon Warren

April 11, 2001

This work is dedicated to my parents,

KEN & BETTY,

for instilling in me the values of hard work,

commitment, and perseverance.

"Do it now

You only have the rest of your life

which passes too quickly to do it yesterday

And too slowly to do it tomorrow

And is never long enough to do it today

And suddenly it's over.

But when you look back

will you say "I did it!"

(Author Unknown)

Abstract

The purpose of this study was to describe and explore nurses' perceptions of empowerment and autonomy and residents' perceptions of their own autonomy in two models of continuing care: assisted living and conventional long term care. Nineteen registered nurses and 43 residents participated in this study. Lower mean scores among nurses in the two conventional long term care centers suggest that they may perceive themselves as having less empowerment and autonomy in the workplace than nurses in the four assisted living facilities did. In addition, lower mean scores among residents in the conventional long term model of care suggest that they may perceive themselves as being less autonomous than residents in the assisted living model of care did. Factors such as organizational structure, philosophy of care, and elements of the physical environment may account for these differences and should be explored in subsequent studies.

Acknowledgements

The author wishes to thank Professor Donna Lynn Smith, thesis supervisor, for her assistance throughout the study and thesis development. Additional appreciation is extended to committee members Dr. Phyllis Giovannetti, Dr. Pauline Paul, and Dr. Sharon Warren.

Thank you to Dr. Rose Gerber for granting permission to use the CONP questionnaire, to Dr. Heather Spence Laschinger for granting permission to use the CWEQ questionnaire, and to Marie Lyle for granting permission to use the Client Survey in this study.

Sincere thank you to Kathy Daly and the not-for-profit caregiving organization for their support of this study. Special appreciation is extended to the nurses and residents within the study sites who gave of their time to participate in this study.

A special note of thanks to the "Hill Family," and to former co-workers Donna Sheptycki and Colleen Arsenault for their ongoing support and encouragement throughout the writing of this study.

Finally, the author wishes to thank Linda Pasmore for formatting this thesis.

Table of Contents

Page

CHAPTER 1: INTRODUCTION 1

Statement and Importance of Problem 1

Research Objectives 4

Significance of the Study 4

Definition of Terms 5

Overview of the Thesis 7

CHAPTER 2: REVIEW OF THE LITERATURE 8

Conceptual Background of Empowerment 9

Empowerment of Clinical Nurses 11

Empowerment of Nurse Managers 16

Factors Related to Nurse Empowerment 18

Empowerment of Patients 24

Resident Autonomy 25

Summary 29

CHAPTER 3: METHODS 33

Research Design 33

Ethical Approval 33

Setting and Subjects 33

Procedure for Selection of Resident Subjects 34

Procedure for Selection of Nurse Subjects 37

Instruments 37

Measure of Resident Autonomy (Client Survey) 37

Reliability and Validity of Client Survey 39

Control Over Nursing Practice (CONP) 40

Conditions of Work Effectiveness Questionnaire 41

Page

Data Collection Procedures 42
Preparation of Research Packets 42
Information Sessions 43
Procedure for Data Collection from Residents 44
Procedure for Data Collection from Nurses 45
CHAPTER 4: RESEARCH FINDINGS 46
Residents' Demographic Data 46
Discussion of Resident Demographic Data 46
Nurses' Demographic Data 48
Discussion of Nurses' Demographic Data 48
Response Rates 51
Analytical Research Findings and Discussion 55
Research Objective #1 55
Research Objective #2 58
Research Objective #3 60
Research Objective #4 62
Research Objective #5 64
Research Objective #6 66
Summary of Findings 70
CHAPTER 5: LIMITATIONS, IMPLICATIONS FOR HEALTH CARE PROVIDERS, AND RECOMMENDATIONS FOR FUTURE RESEARCH 72
Limitations 72
Implications 75
Implications for Health Care Providers 76
Recommendations for Further Research 78

Page

REFERENCES 80

APPENDIX A: LETTERS OF CONSENT 86

APPENDIX B: RESIDENT CHECK LIST 92

APPENDIX C: RESIDENT RESEARCH PACKET 94

APPENDIX D: NURSE RESEARCH PACKET 104

APPENDIX E: INFORMATION SESSION GUIDELINES 112

List of Tables

Table		Page
1.	Kanter's Empowering Strategies	19
2.	Review of Instruments Utilized in Research on Empowerment/Autonomy	29
3.	Physical Features of the Assisted Living and Conventional Long Term Care Centers	34
4.	Resident Check List Responses and Number of Residents Meeting Selection Criteria	35
5.	Frequency and Percent Distribution of Demographic Data From Continuing Care Assisted Living Residents (n=26)	46
6.	Frequency and Percent Distribution of Demographic Data From Continuing Care Long Term Care Residents (n=17)	48
7.	Frequency and Percent Distribution of Demographic Data From Conventional Long Term Care Nurses (n=13)	54
8.	Frequency and Percent Distribution of Demographic Data From Continuing Care Assisted Living Nurses (n=6)	57
9.	Means and Standard Deviations of Nurses' Perceptions of Job-Related Empowerment	62
10.	Means and Standard Deviations of Nurses' Perceptions of Autonomy	64

List of Figures

Figure Page

1. Kanter's (1977) Theory of Structural Power 12

2. Guiding Principles in Response to an Aging Population 37

CHAPTER 1

INTRODUCTION

Statement and Importance of Problem

There is a growing body of research focused on the empowerment of nurses employed in various positions within a variety of health care settings. Most of these studies were conducted in acute care environments, and to date, only a few studies examining empowerment and autonomy of nurses in the continuing care sector have been published. In recent years, new approaches to continuing care have resulted in the development of several innovative program and facility designs. In this study, nurses' perceptions of job-related empowerment and autonomy and residents' perceptions of their own autonomy within two models of continuing care were examined.

The older adult population (65+) is the fastest growing segment in Canada. By 2011 it will comprise over 7.2 million Canadians and by 2031 will constitute one quarter of Canada's population (Angus, Auer, Cloutier, & Albert, 1995). Furthermore, by 2001 it is projected that up to 318,000 older adult Canadians will require institutionalization (Angus et al., 1995). This figure is double that of the 1992 statistics (Angus et al., 1995) and poses several concerns for health care providers.

An increasing older adult population and institutionalized older adult population, in addition to health care restructuring, is contributing to nurses feeling overworked, overwhelmed, and disempowered. These effects may have untoward consequences for continuing care residents, who, researchers suggest, already feel, to some degree, a loss of individualism and autonomy simply by residing in a continuing care facility (Tolley, 1997). In order to meet the growing and diverse needs of the older adult institutionalized population, Alberta's continuing care sector is evolving from the medical model of care as seen in conventional nursing homes and auxiliary hospitals to a social model of care focusing on individualized care and quality of life (Damsma, Eales, Gardner, & Keating,

1998). This paradigm shift in continuing care has also led to the adoption of the term *resident* rather than *patient*, further supporting the philosophy behind the social model of care. Similarly, earlier terminology such as *nursing home, auxiliary hospital*, and *extended care institutions* has been replaced by the term *continuing care center*. The care centers themselves have become increasingly diverse in terms of (a) the type of program(s) offered, (b) location of the facilities, (c) admission criteria, (d) architecture, and (e) philosophy. In 1993 Alberta Health released its role statement regarding continuing care facilities. As part of its overall vision, Alberta Health acknowledged that its abiding philosophy of continuing care is

> to encourage residents to use their abilities to the fullest extent possible and to preserve their identity and individuality, . . . and will acknowledge that each person has the right to make decisions about his/her life and to function with those choices in as normal a setting as possible. (p. 11)

In order to implement such a philosophy, Alberta's continuing care sector developed innovative models of care, such as assisted living, adult family living, and dementia care. These freestanding facilities are conceptually and architecturally designed to enhance the physical, social, and interpersonal environments and subsequent autonomy of residents (Damsma et al., 1998). Much of the literature asserts that residents who once were home owners, providers of families, parents, and family decision makers relinquish much of the control over their lives upon admission to continuing care centers (Tolley, 1997). Furthermore, it has been documented that residents in continuing care view constraints over privacy, routines, and lack of community involvement and personal activities as barriers to their autonomy and individualism (Tolley, 1997).

Despite the development of these new and innovative models of care, fiscal restraints, the prevalence of hierarchical structures, organizational culture, and an expressed need for administrators and managers to run cost-efficient and effective care centers have resulted in a decreased number of caregivers and increased caregiver

workload and stress. These effects have the potential to create an overall sense of disempowerment and, ultimately, lead to diminished quality of care on behalf of continuing care nurses (Spence Laschinger, 1996).

As a result, many nurse administrators have recognized the need for a more empowered nursing staff. However, the conditions and circumstances in which empowerment may be implemented, as well as the management practices necessary to cultivate empowerment, are not clearly understood (Klakovich, 1996). In addition, many investigators examining Kanter's (1977) theory of structural power in health care organizations have identified hierarchical structures as being strong barriers to the creation of an aligned and empowered nursing profession (Goddard & Spence Laschinger, 1997; Spence Laschinger, 1996). Kanter believed that an individual is more likely to achieve organizational and/or unit goals if he/she is provided with the ability to access the structures that foster empowerment: access to information, opportunity, resource, and supplies. Furthermore, a nurse's work environment, referred to as *organizational culture*, which emphasizes shared beliefs, values, behavior, and relationships appear to contribute to nurse empowerment (Klakovich, 1996).

An important aspect of organizational culture is managerial leadership. To create and sustain an empowered work environment, managers need to increase staff resources, capabilities, and effectiveness in the areas that staff say are important: teaching, counseling, listening, comforting and caring (McDermott, Spence Laschinger, & Shamian, 1996). Thus, organizational culture and managerial leadership are believed to both contribute to and facilitate staff-nurse empowerment. Furthermore, it is essential for managers and administrators to understand the impact that empowerment and autonomy have on the quality of nurses' work life and residents' overall quality of life, in addition to the organizational structures necessary to foster nurse empowerment and autonomy.

Research Objectives

The purpose of this study was to describe and explore nurses' perceptions of job-related empowerment and autonomy and residents' perceptions of their own autonomy in two models of continuing care. In undertaking this study, six research objectives were identified. They are as follows:

1. to describe and explore the perceptions of empowerment among nurses in two models of continuing care: assisted living and conventional long term care;
2. to describe and explore the perceptions of autonomy among nurses in two models of continuing care: assisted living and conventional long term care;
3. to describe the similarities and differences in the perceptions of empowerment and autonomy among nurses in two models of continuing care: assisted living and conventional long term care;
4. to describe the differences, if any, of nurses' scores on the opportunity, information, resource, and support subscales, as measured by the Conditions of Work Effectiveness Questionnaire, within two models of continuing care: assisted living and conventional long term care.
5. to describe and explore the perceptions of autonomy among residents in two models of continuing care: assisted living and conventional long term care; and
6. to describe the similarities and differences in the perceptions of autonomy among residents in two models of continuing care: assisted living and conventional long term care.

Significance of the Study

In addition to expanding on previous research in other settings, this study examines the concept of empowerment and autonomy in two different models of continuing care. One model of care (assisted living) is relatively new and innovative, and

the other model of care (conventional long term care) has existed for many years. The researcher was unable to locate any published research on nurse empowerment and autonomy that extends to the consideration of patients'/residents' perceptions of autonomy.

The results of this study may provide administrators and managers within the continuing care sector the opportunity to examine the organizational structures that may be enhancing or limiting nurses' ability to feel empowered and autonomous within the workplace. Furthermore, if nurses perceive that they have limited access to the structures of empowerment and do not feel autonomous in the workplace, then, by association, residents may perceive that they lack the autonomy they require to ensure that the care center functions more like their homes.

The Chinese proverb "Give a man a fish, and you feed him for a day; teach him how to fish, and you feed him for a lifetime" (Beaulieu, Shamian, Donner, & Pringle, 1997, p. 40) is the essence of empowerment. If maintaining or increasing residents' perceptions of their own autonomy is a goal of continuing care, then it is important to understand how nurses' perceptions of their job-related empowerment and autonomy may or may not contribute to autonomy of residents.

Definition of Terms

Within this study, the following terms have been identified and operationally defined.

Residents: Individuals residing in assisted living and conventional long term care.

Registered nurses: Classified in terms of their educational preparation, RN, RN BScN, RN MN or other field, and RN PhD.

Empowerment: Perceived access to the sources/structures of job-related empowerment as measured by the Conditions of Work Effectiveness Questionnaire (CWEQ). The CWEQ is a 32-item Likert scale ordinal questionnaire with four subscales: information,

support, resource, opportunity, and two items of global empowerment for validity purposes. Scoring is obtained by summing the first four subscales and ranges between 4 and 20, with the higher score being indicative of a higher perception of job-related empowerment (Spence Laschinger, 1996).

Nurse autonomy: Defined as the freedom to "evaluate and modify nursing practice, make independent and interdependent decisions related to patient care, exercise authority, assume accountability for the outcomes of decisions and influence the work environment" (Wyckoff Lancero & Gerber, 1995, p. 47). Gerber's Control Over Nursing Practice questionnaire consists of 21 items designed to measure perceptions of autonomy. This questionnaire utilizes a seven-point Likert rating scale of 1 (disagree) to 7 (agree). "Control Over Nursing Practice Scale utilizes a summative, unidimensional measure whereby scores are simply summated and divided by the number of items in the scale" (Gerber, personal correspondence, March 1, 2000).

Resident autonomy: For purposes of this study, resident autonomy is defined in terms of residents' perceptions of independence, choice, and shared decision making; in addition to their right to privacy, safety, and personalized care within their respective continuing care centers as measured by the Client Survey questionnaire. In 1998 Alberta Health pilot-tested the "Client Survey" instrument, one of three instruments developed from an individual perspective to understand "how well the continuing care system performs in the provision of services" (Alberta Health, 1999, p. 5). Although this survey can be used as a measure of several outcomes, it was used in this study as a proxy measure of resident autonomy, as several individual items address choice, personalized care, shared decision making, privacy, respect, safety, daily routines, and independence, each of which was identified by Evans (1996) and Happ, Williams, Strumpf, and Greene Burger (1996) as being critical in establishing and maintaining individualized care and personal autonomy of residents in continuing care. This survey is scored according to a six-point Likert scale with response categories ranging from *strongly agree* to *does not apply*.

Assisted living facility: An innovative residential care facility (not an acute care facility, conventional care center, or auxiliary hospital) within Alberta's continuing care sector. "Assisted Living offers a home-like experience for persons who desire privacy and maximum involvement in decision making" (Good Samaritan Society, 1997, p. 2). Care provided to residents is based on a social model of care, is client focused, and adheres to the principles of *Assisted Living: Independence, Choice, Dignity, Individuality, Privacy, and Home-Like Environment* (Good Samaritan Society, 1997).

Conventional long term care center: In Alberta, persons residing in conventional long term care centers are under the umbrella of the continuing care sector and are referred to as requiring long term care services. *Long term care* is defined by Alberta Health (1998) as the duration of care provided to persons in continuing care centers for a minimum of 90 days. Continuing care centers provide medical and health, social and residential, and personal and supportive services for individuals not able to care for themselves in the community as a result of a chronic illness or physical disability.

Overview of the Thesis

In the following chapter, research literature on nurse empowerment, nurse autonomy, and resident autonomy are reviewed and discussed. In Chapter 3, methods for the study are described. The physical features of the assisted living and conventional long term care centers are presented in the description of the setting and subjects. The research findings are presented in Chapter 4. This chapter begins with a discussion of the response rates and characteristics of subjects. Each research objective is presented with related findings. The chapter concludes with a summary of major findings. In Chapter 5, the limitations of the study, implications for health care providers, and recommendations for future research are discussed.

CHAPTER 2

REVIEW OF THE LITERATURE

In this chapter a systematic review of the literature addressing empowerment and autonomy in nursing is presented. Definitions and the conceptual background of empowerment, empowerment of clinical nurses, empowerment of nurse managers, factors related to nurse empowerment, empowerment of patients, and resident autonomy are explored. The literature presented in each section has been arranged chronologically.

For this study, the literature review was identified from electronic and print resources. First, the Health Sciences database under the subject heading *nursing* and the database Ageline were accessed for abstracts within the past 10 years, using the keywords *nursing home patients, long term care, innovative care centers, health services for seniors, assisted living*, and *patient autonomy*. The same search process and time frame were utilized in accessing the CINAHL database with the key words *empowerment, nurse autonomy, patient autonomy, power, choice, decision making, leadership, organizational structure, assisted living*, and *long term care*. The Healthstar database was searched for abstracts within the past 10 years using the key words *assisted living* and *long term care*. The last database searched was the Health Reference Center with the key word *nursing homes*. Second, an electronic search for articles written by Spence Laschinger was conducted in journals such as *Nursing*, *Nursing Administration Quarterly*, and *Journal of Nursing Administration*. The electronic search process was expanded to access Internet sites of the Canadian Nurses' Association, University of Western Ontario, and Heather K. Spence Laschinger. Third, the review also included a catalogue search at the J. W. Scott Health Sciences Library, University of Alberta, under the subject heading *long term care and autonomy*, in addition to an author search of printed material by Rosabeth Moss Kantor. Last, other references included reports by Alberta Health, Alberta Community Development, and Government of Canada agency agreements and directions. All material

was reviewed by the researcher, and only the literature deemed relevant to the review and the study was included.

Conceptual Background of Empowerment

Empowerment is believed to have emerged from the social-action philosophies of the 1950s (Gibson, 1991). Since then, the concept of empowerment has assimilated into health care through such contexts as health promotion (Grace, 1991; McWilliam et al., 1997; Wallerstein, 1992); health education (Carlson-Catalano, 1992; Wallerstein & Bernstein, 1988); and staff, community, and organizational empowerment (Beaulieu et al., 1997; Sullivan Havens & Mills, 1992; Marion, Mathews, Kirkpatrick, & Goulding Streifel, 1995; O'Neill, 1992; Spence Laschinger, 1996; Thyen, Theis, & Volk Tebbitt, 1993). The concept of *empowerment* has been used by several disciplines, including nursing. Empowerment is most frequently defined in terms of the context in which it is used. However, many definitions exist within the literature, and the concept remains abstract and problematic.

Broadly defined, empowerment is a process that enables individuals to feel worthy and effective (Chandler, 1992). From a theoretical perspective, Rappaport (1987) defined empowerment as "enhance[ing] the possibilities for people to control their own lives" (p. 121), which occurs through a "relationship between a person and his or her community, environment and something outside one's self" (p. 121). According to Keiffer (1984), nurses often define empowerment in terms of its absence rather than its presence. Within the context of a nursing unit, Naude (1997) stated that empowerment means to authorize, delegate, enhance self-sufficiency, invest and share power, and "create an environment . . . that encourages the leader and followers to work towards achieving their potential and focus on the needs of the leader and followers to encourage self-responsibility by altering self-limiting beliefs" (p. 34). In addition, the amount of

empowerment nurses perceive they have within the workplace is defined in terms of their access to the sources of empowerment, which are information, opportunity, support, and resource (McDermott et al., 1996). Expanding on previous definitions, Klakovich (1996) implied that empowerment among nurses and nurse managers is achieved through reciprocity; whereas in 1991, Gibson looked at the process of empowerment among patients and stated that it involves "helping individuals assert control over the factors that affect their health" (p. 96).

Despite the widespread contextual dimension of empowerment, Skelton (1994) acknowledged that the concept is used inconsistently and inappropriately by many disciplines. To clarify the use of this concept within nursing, Rodwell (1996) undertook a formal conceptual analysis of empowerment. In examining the literature on power, choice, and enablement, Rodwell determined that empowerment is a dynamic, positive, didactical concept encompassing a helping process and a philosophy of collaboration with others, problem solving, mutual decision making, self-determination, and acceptance of responsibility. Rodwell (1996) believed that conceptualizing and analyzing empowerment contributes directly to the unique body of nursing knowledge and are intrinsic factors if nursing is to attain power, credibility, and autonomy.

In concert with this view, the focus of the following review of research findings pertains to nurses' and nurse managers' perceptions of job-related empowerment, in relation to such factors as commitment, decision making, and efficacy. Within the context of continuing care, it is highly relevant to consider the perceptions of nurse empowerment and autonomy and resident autonomy. Furthermore, nurses' perceptions may intuitively affect the degree of autonomy experienced by residents.

Empowerment of Clinical Nurses

Nursing literature documents the need for nurses in clinical or direct-care roles to become more empowered and autonomous (Marion et al., 1995; Spence Laschinger & Sullivan Havens, 1996). Klakovich (1996) and Porter-O'Grady (1998) suggested that empowerment among nurses can be achieved through such interactive models as decentralization, shared governance, participative decision making, case management, and patient-focused care. However, for such models to be implemented, an understanding of the conditions, circumstances, and practices that foster empowerment is necessary.

As continuing care administrators, nurse managers, and nurses shift toward a philosophy of client-centered care through the creation of a decentralized milieu, there is renewed interest in empowerment and, in particular, nurses' perceptions of empowerment. Of particular interest is the fact that empowerment can be viewed as either a process (independent variable) or an outcome (dependent variable). Whether empowerment is conceptualized as a process or an outcome determines how it will be studied and understood.

The majority of research about empowerment of nurses and direct-care practices has focused on the exploration and testing of Kanter's (1977) original theory of structural power in health care organizations (Figure 1) and is linked to nurses' job satisfaction, organizational commitment, productivity, and self-efficacy (Beaulieu et al., 1997; Chandler, 1991, 1992; Goddard & Spence Laschinger, 1997; McDermott et al., 1996; Sabiston & Spence Laschinger, 1995; Spence Laschinger, 1996; Spence Laschinger & Shamian, 1994; Spence Laschinger & Sullivan Havens, 1996). Although these researchers have provided important studies on nurse empowerment within an acute care environment, only one study was located to extend beyond this population and examine staff-nurse empowerment within a continuing care facility (Beaulieu et al., 1997). To date, there is limited published research reporting nurse managers' perceptions of

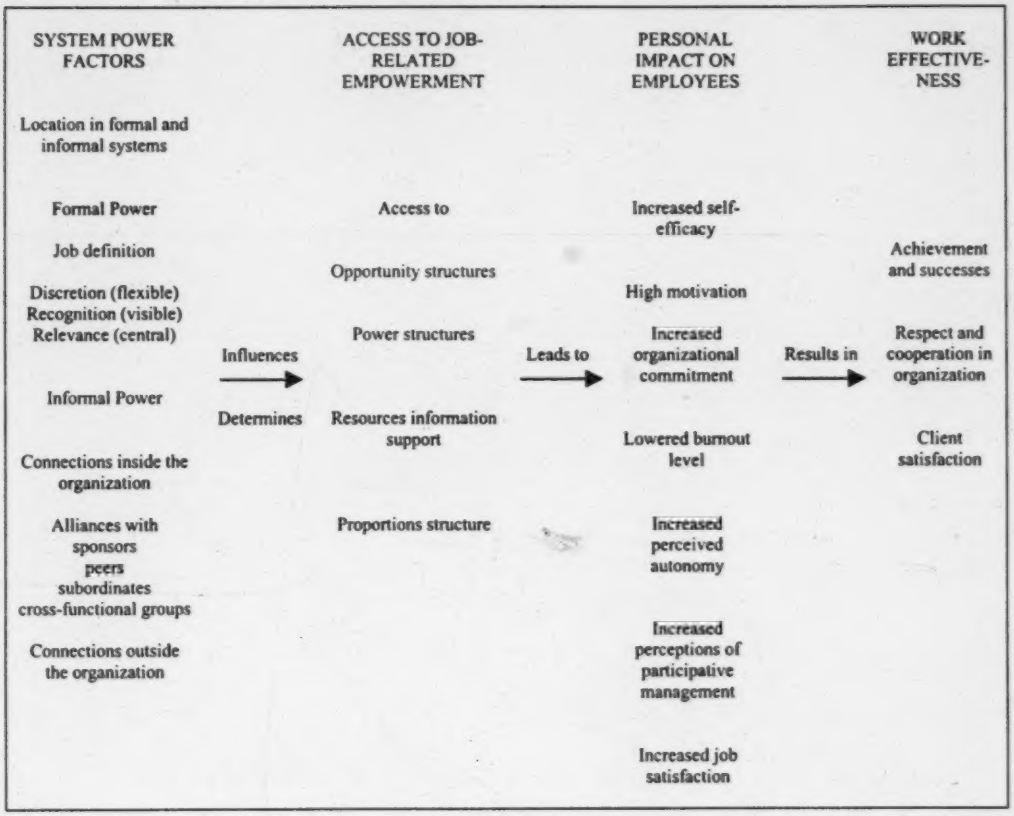

Figure 1. Kanter's (1977) theory of structural power.

empowerment (Goddard & Spence Laschinger, 1997; McNeese-Smith, 1997), in addition to staff nurses' and nurse managers' perceptions of job-related empowerment (Haugh, 1992; Spence Laschinger & Shamian, 1994).

In 1992 Chandler asserted that to implement empowerment strategies and practices effectively into clinical nursing, one has to first understand the source of clinical nurse empowerment. Alternatively, Attridge (1996) identified the need to understand and examine sources of powerlessness within nursing, thus laying a foundation from which nurses' vision of an empowering and autonomous profession could begin to flourish.

An exploratory descriptive investigation by Chandler (1992) comprised a sample of 56 clinical nurses employed in either a health care center or a community health center, with data collected by way of surveys and personal interviews. The results indicate that nurses felt most empowered during patient-family interactions (59%), when they were complimented or verbally acknowledged by physicians (23%), when they were complimented by a superior (7%), and when they worked in a cohesive environment (7%). Interestingly, nurses identified negative interactions with physicians as the single most contributing factor to their feeling powerless, which is consistent with later findings by Attridge (1996).

A descriptive correlational study conducted within a large metropolitan hospital examined the organizational structures influencing 101 nurses' perceptions of job-related empowerment and autonomy. Nurses employed full-time for 12 months in the care areas of critical care, medical/surgical, specialty areas, and maternal child were eligible to participate. This 1995 Canadian study by Sabiston and Spence Laschinger utilized the Conditions for Work Effectiveness Questionnaire (CWEQ) originally developed by Kanter (1977) and later adapted by Chandler (1991). This instrument measures individuals' perceptions of job-related empowerment or access to the sources of empowerment. The CWEQ is a 32 item instrument consisting of four subscales: Support (9 items): an individual's ability to partake in risk-taking behaviors and extraordinary activities without having to obtain approval from the many layers that makeup an organizations hierarchical structure (Spence Laschinger, Wong, McMahon, & Kaufmann, 1999); Opportunity (7 items): the chance to grow and move in the organization (Spence Laschinger et al., 1999); Information (8 items): an individual's "knowledge of organizational decisions, change in policy and future direction" (Spence Laschinger et al., 1999); Resources (7 items): an individuals "ability to exert influence in the organization to bring in needed materials, human or financial and other supplies needed to do the job" (Spence Laschinger et al., 1999). A global measure of empowerment (2 items) was added

in 1995 and is used for validity purposes (Spence Laschinger, personal correspondence, April 2000). An overall empowerment score (4-20) is obtained by summing the first four subscales. This questionnaire has been used extensively in the study of nurse empowerment. Within this study, alpha reliability for the CWEQ (subscales and overall empowerment) ranged between 0.76 and 0.84 (Sabiston & Spence Laschinger, 1995). The Job Activity Scale, a Likert questionnaire, describes respondents' perceptions of their formal power characteristics: recognition, relevance, and discretion (alpha reliability 0.85) ; whereas the Organizational Description Questionnaire (Part B) elicits subordinates' perceptions of their supervisors' organizational power (alpha reliability 0.89). In addition, the Job Description Questionnaire measures individuals' perceptions of workplace autonomy (alpha reliability 0.85).

Data analysis indicates that nurses in Sabiston and Spence Laschinger's (1995) study possessed a moderate degree of job-related empowerment (M=11.20; SD-1.90). This finding is consistent with the findings reported by McDermott et al. (1996), Spence Laschinger and Shamian (1994), and Spence Laschinger and Sullivan Havens (1997). In addition, nurses perceived their access to informal power systems (relationships with peers, subordinates, or cross-functional groups) as their primary source of job-related empowerment. Similarly, Spence Laschinger et al. (1997) acknowledged in their study examining nurses' perceptions of work empowerment and involvement in decision making that nurses who perceived having greater access to informal power systems had greater access to work-empowerment structures and felt more empowered. Sabiston and Spence Laschinger utilized a number of multiple regression techniques on the study variables and determined that 48% of the variance of job-related empowerment derived from the antecedents to empowerment, which in this study proved to be nurses' access to informal as well as formal organizational power structures. Further findings recognize nurses' perceptions of informal power structures and job-related empowerment as a direct correlation to their degree of workplace autonomy. These findings support Kanter's

(1977) hypothesis that individuals who have access to informal/formal power structures in addition to sources of job-related empowerment are more autonomous (Spence Laschinger, 1996; Spence Laschinger & Shamian, 1994). The sampling method used in the study by Sabiston and Spence Laschinger (1995) was purposive, and, as such, 60% of the nurses did not respond. Perhaps a response rate bias between care areas on differences in demographic variables accounted for the 40% response rate. A discussion of the representativeness of respondents vs. nonrespondents was also not mentioned in the article. For these reasons and because of the use of only one testing site, the findings are generalizable to the subject groups only.

Hatcher and Spence Laschinger (1996) examined nurses' perceptions of job-related empowerment and burnout, using a descriptive correlational design. Participants reported limited access to sources of job-related empowerment and subsequently perceived that they possessed moderate levels of empowerment (overall empowerment: M=10.66; SD-2.22) as measured by the CWEQ. Alpha reliability for this study ranged between 0.79 and 0.91 (Hatcher & Spence Laschinger). This finding is consistent with the research results reported by Chandler (1986). However, these researchers further acknowledged that, overall, nurse participants did not exhibit a high degree of burnout (M=20.75; 5.75; 41.28), which is inconsistent with Maslach and Jackson's (1982) proposition that, by virtue of their profession, nurses lack power and opportunity and are therefore vulnerable to burnout. Only one hospital was involved in the study and only full-time RNs were invited to participate, provided that they had worked in their current practice area longer than six months. For this reason generalizability of the findings are limited to study subjects and care facility.

Empowerment of Nurse Managers

Whereas there is limited research into clinical nurses' perceptions of empowerment, perceptions of nurse managers have received even less study. In 1996 Klakovich developed and tested an empowerment model for clinical nurses in an effort to determine which characteristics contributed to the empowerment of nurses. Although the literature suggested that age, experience, education, and position are antecedents to empowerment (Wilson & Spence Laschinger, 1994), Klakovich expanded her model to assess the relationship between personal characteristics, organizational culture, leadership, and empowerment. The Reciprocal Empowerment Scale designed by Klakovich is a 24-item Likert scale questionnaire with subscale items measuring synergy, ownership, and reciprocity. The total score obtained indicates the extent to which nurses feel empowered. The Organizational Inventory, a five-point Likert scale questionnaire, measures an organization's culture as either constructive, passive-defensive, or aggressive-defensive. In addition, the Achieving Styles Inventory, a seven-point Likert scale questionnaire measuring connective leadership (individuals' ability to utilize implementation strategies to attain desired goals), provided Klakovich with empirical evidence suggesting that organizational culture and connective leadership are strong determinants of nurse empowerment. Furthermore, in this study involving 245 nurses from two southwestern United States health care centers, personal characteristics were not found to contribute to nurse empowerment. However, nurses' levels of education and positions within these two organizations were moderately related to their degree of connective leadership. The results indicate that nurses in higher positions in the organization had greater connective leadership scores and subsequently felt more empowered.

In a recent study, Goddard and Spence Laschinger (1997) analyzed positional access to power and opportunity within three urban Canadian hospitals, utilizing a

convenience sample of 75 first-line managers and 16 middle managers. Employing the CWEQ (alpha reliability first line manager group, .77-.88; and middle manager group, .76-.92) and ODO, Parts A and B in this study, middle managers perceived that they possessed significantly greater access to empowerment structures (M=14.66; SD=2.32) than did first-line managers (M=12.82; SD=1.77, t[79]=-3.43, P<.001). Moreover, middle managers who had access to organizational empowerment structures considered this as ultimately contributing to their overall sense of personal power (M=3.32; SD=0.67), which in this study proved statistically to be greater than the personal power of first-line managers (M=2.53; SD=0.72, t[85]=-.406, p<.000). The findings from this study support Kanter's (1977) contention that power and opportunity are readily accessible to individuals positioned in the upper hierarchical structures of organizations and that power increases as one increases one's position in the hierarchy of the organization. Similar findings by Spence Laschinger and Shamian (1994) support this proposition.

Spence Laschinger and Shamian (1994) utilized Quinn's Competing Value Model outlining managerial competencies and Kanter's (1977) theory of structural power to examine the relationship between empowerment and self-efficacy of nurse managers (n=27), in addition to examining differences between staff nurses' (n=109) and nurse managers' cognition of job-related empowerment. Spence Laschinger and Shamian (1994) reported that staff nurses had moderate access to sources of empowerment (M=11.65; SD=2.21), whereas nurse managers perceived that they had greater access (M=14.65; SD=1.40). Not surprisingly, nurse managers scored higher on the ODO (Part B), an indication that they perceived that they possessed more organizational power than clinical nurses perceived that they held. These findings suggest that having access to sources of empowerment directly correlates with managerial self-efficacy and positive work performance of nurse managers. Further, nurse managers' perceptions of self-efficacy were directly related to their ability to access support, opportunity, and

information within the organization. Alpha reliabilities for the manager group ranged between 0.67 and 0.89 and for the staff group, between 0.68 and 0.88.

Limitations of this study include the relatively small sample size and the fact that the study was conducted in only one setting. In addition, the degree to which respondents were representative of the target population is not discussed, which affects the generalizability of the findings. However, the findings from the CWEQ and ODO do show support for Kanter's (1977) theory tested in the study and are similar to findings reported in studies previously discussed in this literature review. Spence Laschinger and Shamian (1994) suggested that organizations wanting to improve staff nurses' and nurse managers' overall access to sources of empowerment within an organization should look at instituting Kanter's empowering strategies, as outlined by Spence Laschinger and Shamian (Table 1). Furthermore, Kramer and Schmalenberg (1993) suggested similar strategies for increasing access to empowerment structures. These include participative management, goal setting, involvement of staff in decision making, and supporting autonomous behaviors.

Factors Related to Nurse Empowerment

In the literature, factors such as commitment, job satisfaction, decision making, efficacy, and autonomy were identified as being related to nurse empowerment. Most studies included in this section utilized descriptive correlational designs with sample sizes ranging between 30 and 285.

The amount of work-related empowerment that a nurse perceives that he/she holds has been shown to be directly correlated with how committed an individual is to a given institution (Beaulieu et al., 1997). Two studies examining the variables of job-related empowerment and commitment were found in the literature, with one being conducted in an acute care hospital with a sample size of 112 registered nurses (McDermott et al., 1996), and the other in two continuing care centers with sample sizes

of 19 first-line managers, 155 registered nurses, and 170 registered practical nurses (Beaulieu et al., 1997).

Table 1

Kanter's Empowering Strategies

Sources of power	Strategies to empower
Opportunity	Job enrichment, rotation, redesign Create new job ladders as alternative to upward success Define tasks and knowledge needed for each job Performance appraisal to track progression
Lines of information	Seek out and ask for information Share information to build trust and cooperation Communicate and celebrate successes Take credit for your ideas
Lines of support	Building bridges with peers, superiors, subordinates Recognize achievements Support innovation, risk taking behavior
Lines of supply	Increase discretionary power (autonomy) Influence decisions that impact the role

(Adapted from Spence Laschinger & Shamian, 1994)

McDermott et al. (1996) replicated an earlier study by Wilson and Laschinger (1994) to examine the relationship between nurses' perceptions of job-related empowerment and organizational commitment, in addition to the relationship between job-related empowerment, organizational commitment, and managerial power. Within the context of this study, *organizational commitment* is defined in two ways. *Attitudinal commitment* refers to an individuals' willingness to remain in the organization. *Calculated organizational commitment* refers to an individual's perception of a need to

stay within a given organization. To measure commitment as a dependent variable, a self-reported OCQ was utilized to measure the attributes of commitment: (a) the degree to which an individual internalizes organizational goals, (b) the organizational contributions that an individual is willing to make, and (c) individual desire for organization retention (Mowday, Steers, & Porter, 1979). Questionnaires similar to those used by Goddard and Spence Laschinger (1997) and Spence Laschinger and Shamian (1994) were employed to measure work-related empowerment and managerial self-efficacy.

Nurses were found to be more committed to the goals of the organization when they perceived that they had greater access to empowerment structures, in addition to the opportunity to grow, learn, and advance within the organization. (Beaulieu et al., 1997; McDermott et al., 1996). Furthermore, both studies supported Kanter's (1977) contention that staff nurses' job-related empowerment increases by association when managers are perceived to possess significant organizational power. The results from both studies are surprisingly similar, despite the fact that continuing care centers are often structurally and hierarchically different from acute care centers.

Beaulieu et al. (1997) showed front-line managers to be more empowered and committed to the organization than registered nurses and practical nurses. However, no differences were noted between registered nurses' and practical nurses' perceptions of job-related empowerment and commitment. This may be explained by the fact that the job descriptions and roles of registered nurses and practical nurses were similar within the continuing care centers.

In 1997, McNeese-Smith conducted a descriptive study using 30 nurses from Los Angeles County Hospital to identify what staff nurses perceived and what they reported that their managers do to increase productivity, satisfaction, and organizational commitment within the workplace. The following behaviors exhibited by managers are perceived to increase job satisfaction among clinical nurses: (a) giving recognition, (b) meeting personal needs, (c) support of the team, and (d) visionary and growth

orientation. Overall, staff nurses acknowledged that being thanked by the manager significantly contributed to their satisfaction, productivity, and commitment in the work place.

Several researchers have concluded that, for health care organizations to create and sustain empowering work environments, nurses must acquire control over their work environments through shared decision making and autonomy (Spence Laschinger, Sabiston, & Kutszcher, 1997). Autonomy among nurses has been defined as a process of self-governance and the ability of individuals to independently and functionally control their work environments (Blanchfield & Biori, 1996), in addition to the independence "to make discretionary and binding decisions consistent with one's scope of practice and freedom to act on these decisions" (Lewis & Batey, 1982, p. 15).

In 1996 Spence Laschinger and Sullivan Havens utilized Kanter's (1977) theory of structural power to examine the relationship between clinical nurses' perceptions of job-related empowerment and degree of control over nursing practice, work satisfaction, and work effectiveness. Two hundred registered nurses were randomly selected from two urban and suburban teaching hospitals located in the southeastern part of the United States. Through the hospitals' internal mail systems, the participants received packets containing five questionnaires: CWEQ; JAS; ORS; Gerber Control over Nursing Practice Questionnaire, which is designed to measure nurses' perceptions of autonomy or control over their practice environments and is "particularly relevant for measuring current conceptions of professional nursing practice" (p. 30); and the Bass Multifactor Leadership questionnaire, which measured job satisfaction and work effectiveness. Spence Laschinger and Sullivan Havens (1996) acknowledged that the alpha reliabilities for all scales used in this study ranged between 0.76 and 0.95.

The findings indicate that nurses from both hospitals perceived that they were moderately empowered (Hospital A: M=11.0, SD=2.58; Hospital B: M=10.81, SD=2.68) and autonomous (Hospital A: M=4.46, SD=1.13; Hospital B: M=4.45, SD=1.31). A

strong correlation was found between nurses' perceptions of job-related empowerment and autonomy ($r=0.625$; $p=0.000$). This positive correlation supports Kanter's (1977) theory that within a hospital setting, clinical nurses' access to job-related empowerment factors enables them to exercise control over work environments (Spence Laschinger & Sullivan Havens, 1996). In addition, positive correlations were found between control over nursing practice and informal power, and between job-related empowerment factors and work satisfaction and effectiveness. Furthermore, these results clearly demonstrate that autonomy is an essential element in nursing practice (Spence Laschinger & Sullivan Havens, 1996). Alpha reliabilities for questionnaires in this study were grouped and reported to range from 0.76 to 0.95. Specific mention of validity testing pertaining to the questionnaires in the study was not included in the research article.

The response rate of 33% is relatively low and alerts the reader to the possibility of response bias. This, however, is not mentioned in the study and serves as a limitation. As this study involved nurses randomly selected from two hospitals, the researchers acknowledge that the respondents may not be representative of other acute care settings, but do not mention whether they are representative of nurses from the centers in which they work. This too is a limitation of the study. However, empirical findings lend support to the hypothesis of the study and the "validity of Kanter's theory in nursing settings" (Spence Laschinger & Havens, 1996, p. 32).

In the nursing literature, autonomy has been found to be related to nurses' work effectiveness (Spence Laschinger, Sabiston, & Kutszcher, 1997; Spence Laschinger & Sullivan Havens, 1996) and empowerment (Marion et al., 1995). On closer analysis, all of the aforementioned studies, although different in context, yielded similar results. Nurses in these studies felt moderately empowered, which is consistent with the findings from previous studies, and perceived that they possessed a moderate to moderately high degree of control over the content and context of their work environment and practice.

Empowerment of Patients

Research into patient empowerment is minimal, with few empirical studies located and deemed pertinent to this review of literature. As with nurse empowerment, the concept of patient empowerment can be used in research as an independent variable, with outcomes such as self-efficacy, perceived control, and increased well-being, and can also be treated as a dependent variable with factors such as participative decision making and support leading to patient empowerment and autonomy (Vander Henst, 1997). There is a belief that professional groups such as nurses cannot empower patients, that only the patient can empower him/herself. Nonetheless, the nursing literature has generally contended that nurses can remove or alter barriers to patient empowerment.

Roberts, Krouse, and Michaud (1995) conducted an experimental study that examined the introduction of negotiation methods to increase patient participation in their health care. A total of 98 university students comprised the sample, which was divided into those who received a negotiated approach to decision making and those who did not. It is not surprising that the respondents in the experimental group felt that they had more control over treatment decision and treatment plans and, consequently, felt more empowered.

In long term care, some studies have shown that nurses believe residents cannot empower themselves because many suffer cognitive impairment. However, as noted by Meddaugh and Peterson (1997), empowerment emphasizes the "rights and abilities of each elderly resident, rather than his/her deficits and needs, . . . and denotes the ability of elderly residents and their caregivers to change their tomorrows" (p. 33). Furthermore, the authors acknowledged that to increase patient empowerment, administrators should focus on fostering conditions such as access to information and services and enhancing patients' autonomy and decision-making capabilities.

Resident Autonomy

With the emphasis strongly placed on empowerment and autonomy, the nursing literature increasingly refers to individuals in long term care centers as *residents*, thus solidifying a permanent change in nursing and social philosophy. In North American culture, autonomy is a highly regarded philosophical ideology and is the epitome of societal goals and values (Agich, 1993). As demonstrated in the past, the majority of continuing care centers have operated under the medical model of care, which is largely viewed as inappropriate if the center is to reflect the resident's home (Marmoll Jirovec, & Maxwell, 1993). However, as more continuing care centers have aligned their philosophical missions to reflect a social model of care, confusion remains as to what role residents currently have and what role they should have in terms of their degree of self-determination and autonomy.

Four research articles/reports were reviewed in which factors such as choice, individuality, and physical environment are identified as relating to or influencing autonomy of residents residing in various facilities within the continuing care sector. Interpersonal organization, physical environments, and their subsequent relationship to resident autonomy were examined within four nursing homes (Ryden, 1985). One hundred and thirteen cognitively sound residents completed the Resident Questionnaire and the Situation Control of Daily Activities Scale (SCDA), designed to elicit resident privileges and perception of control. Another sample comprising 137 caregivers (registered nurses, practical nurses, and nurse aides) and administrative staff completed the Measure of Environmental Support for Autonomy (author developed; no reliability or validity testing was reported) and a smaller version of the SCDA to measure staff beliefs regarding staff practices, institutional policies, architectural milieu of the facilities, and perception of resident autonomy. Although the results indicate that the caregivers were the primary decision makers, a desire to facilitate greater resident involvement and

control over activities of daily living was expressed by most caregivers. There were, however, differences among resident and caregiver perception of resident control and choice of participation in daily living activities. Notably, the most distressing statistic shown in Ryden's (1985) study indicates that 30% of caregivers and 50% of administrative staff did not provide residents with choices regarding participation in activities associated with daily living. One caregiver articulated his/her viewpoint as follows: "I don't believe residents should have that much say about their lives being they are confined in a nursing home and have to take medicines" (Ryden, 1985, p. 365).

Overall, residents in Ryden's (1985) study perceived that they had more control over daily living activities than staff perceived them to hold. Despite this, resident and caregivers agreed that the daily activities of eating and grooming were areas in which residents actually had the least control. The residents further felt that they lacked access to information regarding institutional policies and grievance processes, as well as shared decision making in the development of individual care plans. Gamroth, Semradek, and Tornquist (1995) asserted that one of the most essential steps in promoting and supporting resident autonomy is through shared decision making in the creation, updating, and/or changing of residents' individual care plans.

Jang's (1992) study, in which residents and nursing staff within two long term care centers completed a revised version of the Importance, Locus, and Range of Activities Checklist (n=20), which rated their perceptions regarding the importance and choice of resident participation in daily living activities, indicated that residents and staff concurred on the importance of 11 out of 20 indicators and 10 indicators pertaining to their level of choice. Statistically significant differences occurred among residents and staff perceptions on the importance and choice of daily living activities on 14 of the 20 indicators. The aspects of daily living activities that nursing staff felt were important to residents was, for the most part, not congruent with residents' perceptions. Thus, if staff are not aware of the discrepancies occurring with regard to significance and freedom of

choice that residents associate with activities of daily living (Jang, 1992), they may be facilitating functional decline of residents' physical and psychological well-being.

In another study, Marmoll Jirovec and Maxwell (1993) concluded that Michigan residents from urban and suburban long term care centers perceived that they had a moderate amount of choice regarding their participation in daily living activities. Juxtaposed to this was the result suggesting that residents desired a greater degree of choice than they perceived that they had. In explaining these results, Marmoll et al. contended that in long term care facilities in which residents' control over activities of daily living is often regulated, it is much simpler for nursing staff to complete daily living activities for residents in an expedited manner rather than request input from the resident, which may be viewed by caregivers as an interference or obstacle to their care. What is more, those residents whose dependence on nursing staff increased also exhibited helplessness, a decreased perception of control, and a desire for control (Meddaugh & Peterson, 1997). These findings suggest that empowering long term care residents to sustain autonomous behaviors will most likely contribute to their overall sense of purpose and well-being.

In a more recent Canadian study, Damsma et al. (1998) examined client-centered care within two very unique continuing care models in Alberta: assisted living and adult family living. This study intended to measure residents' quality of life in areas of choice, independence, and authenticity "based on a resident's values, preferences, routines, and life history" (p. 1). A total of 46 residents with varying degrees of cognition and functional ability consented to participate. Participants from assisted living (n=16) scored higher (M=27.4) on the MMSE than did participants from adult family living (n=30; M=23.69). In addition, 34 residents completed the Sense of Coherence Scale (SOC), designed to measure overall outlook on life. However, many residents had difficulty completing the scale; thus the data obtained from the SOC were not used. All residents participated in a qualitative interview designed to elicit residents' perceptions of what it

is like to live in their respective care centers. The residents identified maintaining control, protection of privacy, remaining connected to the community, and socialization outside the facility as important factors in support of their authenticity and quality of life.

As reported by Evans (1996), nursing leaders of long term care settings in Norway, Sweden, and Denmark strive to "add life to years, not years to life" (p. 16) by posing the following question to staff and residents: "How can we make it a place where it is nice to be, where one wouldn't want to leave?" (p. 16). Their response was individualized care for residents. Happ et al. (1996) defined *individualized care* as "an interdisciplinary approach which acknowledges elders as unique persons and is practiced through consistent caring relationships congruent with past patterns and individual preferences" (pp. 7-8). To achieve individualized care and enable residents to be more in control (autonomous) while residing in continuing care centers, Happ et al. reported that nursing staff should aim to maintain resident identity and personal relationships; and encourage independence, shared decision making, and participation in care plans and activities of daily living. The nursing literature recognized the attributes of individualized care as knowing the patient, personal relationships, choice, and participation (Evans, 1996; Happ et al., 1996). Research supporting these attributes of individualized care as factors that influence resident autonomy has been documented by Davies, Laker, and Ellis (1997), Tolley (1997), and Damsma et al. (1998).

Much of the research focusing on resident autonomy concluded that the consequences of aging combined with institutionalization severely undermine residents' freedom of choice, physical and psychological well-being, and ability to remain autonomous (Jang, 1992). Limited Canadian research exists documenting long term care residents' perception of freedom of choice over areas of daily living that are of importance to them (Jang, 1992).

Summary

As mentioned throughout this review of literature, the majority of findings from the studies are generalizable to the respective subject groups. Several of the researchers tested Kanter's (1977) theory and used questionnaires (CWEQ) to measure perceptions of empowerment and other attributes believed to be related to empowerment (CONP, ODO). The attributes examined and questionnaires used in the many studies conducted in the area of empowerment and autonomy are presented in Table 2. As the CWEQ has been widely used in the study of nurse empowerment and findings (CWEQ and support of Kanter's theory) from various settings (acute care and long term care) and positions (staff nurses, first line managers, and middle managers) appear to yield similar results, it can be assumed that in this study the results from the CWEQ should be comparable and generalizable to other continuing care settings. The CONP questionnaire has for the most part been used in a few studies conducted in acute care, but has not revealed enduring relationships in which the findings may be said to be generalizable to other settings and populations. Without further research in the continuing care sector in which the CONP questionnaire is used, the findings from this study may not be generalizable to other continuing care settings.

One can draw the following conclusions from this literature review:

1. Empowerment has for the most part been examined as an independent variable, and related to such factors as nurses' job satisfaction and commitment or residents' perceived control and increased well-being.

2. The majority of research pertaining to nurse empowerment and resident autonomy has been conducted in acute care facilities and frequently focuses on the two variables as being separate and distinct, thus ignoring the possibility that nurse empowerment and autonomy within continuing care centers may play vital roles in maintaining and sustaining the autonomy of residents.

3. There has been limited research describing nurses' perceptions of job-related empowerment and autonomy within continuing care settings. Residents' perceptions of their own autonomy in these settings has also received limited study. This study has been designed to begin to address these gaps in knowledge.

Table 2

Review of Instruments Utilized in Research on Empowerment/Autonomy

Author	Setting	Attributes	Instruments
Ryden (1985)	Four nursing homes	Autonomy	The Resident Questionnaire Situational Control over Daily Activities Measurement of Environmental Support for Autonomy Staff version of the SCDA
Chandler (1991)	Two acute care community hospitals	Empowerment	Questionnaire adapted from Kanter's Conditions of Work Effectiveness
Chandler (1992)	Two community hospitals and three medical centers	Empowerment occupational mental health and work effectiveness	Conditions of Work Effectiveness Questionnaire Job Activity Scale Organizational Relationship Scale
Jang (1992)	Two intermediate care centers (BC)	Autonomy	Revised Edition of the Importance, Locus, and Range of Activities Checklist
Marmoll Jirovec, and Maxwell (1993)	Four urban and suburban nursing homes (MI)	Choice and decision making	Appraisal of Self-Care Agency Katz Index of Activities of Daily Living
Spence Laschinger and Shamian (1994)	Teaching hospital (ON)	Job-related empowerment and managerial self-efficacy	Conditions of Work Effectiveness Questionnaire Organizational Description Opinionnaire (Part A and B) Managerial Self-Efficacy Questionnaire

(table continues)

Author	Setting	Attributes	Instruments
Kruzich (1995)	Five nursing homes (midwest US)	Empowerment and decision-making influence	Self-Perceived Staff Influence on Resident Care Items Influence on Personnel Index
Marion et al. (1995)	Community hospital (WA)	Autonomy & empowerment	Preference for Decision-Making Autonomy Scale Leadership Feedback Questionnaire
Sabiston & Spence Laschinger (1995)	Large metropolitan acute care teaching health center	Empowerment & autonomy	Conditions of Work Effectiveness Questionnaire Job Activities Scale Job Description Questionnaire Organizational Description Questionnaire Organizational Relationship Questionnaire
Attridge (1996)	Various health care centers throughout BC	Powerlessness in nursing	Interview
Clearly Blanchford & Biordi (1996)	Four midwest hospitals (two inner city/two suburban)	Empowerment autonomy & authority	Nursing Authority and Autonomy Scale
Hatcher & Spence Laschinger (1996)	Acute care hospital (ON)	Power, opportunity & burnout	Conditions of Work Effectiveness Questionnaire Human Services Survey
Klakovich (1996)	Healthcare center southwestern US	Organizational culture, connective leadership & empowerment	Organizational Culture Inventory Achieving Styles Inventory Reciprocal Empowerment Scale
McDermott et al. (1996)	Acute care teaching hospital in south-central ON	Job-related empowerment & commitment	Conditions of Work Effectiveness Questionnaire Organizational Description Opinionnaire Part B Organizational Commitment Questionnaire
McNeese-Smith (1997)	Los Angeles County Hospital	Job satisfaction, productivity & commitment	Structured Interview Guide

(table continues)

Author	Setting	Attributes	Instruments
Spence Laschinger & Sullivan Havens (1996)	Two urban teaching hospitals (southwestern US)	Empowerment, control over nursing practice	Conditions of Work Effectiveness Questionnaire Organizational Relationship Scale Job Activities Scale Gerber Control over Nursing Practice Bass Multifactor Leadership Questionnaire (measures job satisfaction and work effectiveness)
Beaulieu et al. (1997)	Two long term care centers (ON)	Job-related empowerment, organizational commitment and managerial power	Conditions of Work Effectiveness Questionnaire Organizational Description Opinionnaire Part B Organizational Commitment Questionnaire
Goddard & Spence Laschinger (1997)	Three Canadian urban teaching hospitals	Job-related empowerment & personal power	Conditions of Work Effectiveness Questionnaire Organizational Description Opinionnaire Part A & B
Spence Laschinger, Sabiston, & Kutszcher (1997)	Acute care hospitals (central Canadian provinces)	Empowerment & decisional involvement	Conditions of Work Effectiveness Questionnaire Job Activities Scale Organizational Relationship Scale Work Unit Description Scale
Spence Laschinger & Sullivan Havens (1997)	Urban acute care center (NC)	Empowerment, occupational mental health & work-effectiveness	Conditions of Work Effectiveness Questionnaire Job Activities Scale Organizational Relationship Scale

CHAPTER 3

METHODS

This chapter contains five sections providing a description of the research methods used in the study. The first two sections describe the research design and process of obtaining ethical approval prior to commencement of the study. The third section describes the setting and subjects eligible for the study, and the fourth section describes instruments used for data collection. The last section outlines procedures for data collection.

Research Design

Limited research has been conducted to examine either the empowerment and autonomy of continuing care nurses or the autonomy of continuing care residents. Nurses' perceptions of empowerment and autonomy and residents' perceptions of their own autonomy have not been studied concurrently in two different models of continuing care. A descriptive exploratory design was therefore used in this study.

Ethical Approval

In order to access continuing care nurses and residents in each of the study's assisted living facilities and long term care centers, the researcher received ethical approval from the Health Research Ethics Board (HREB), University of Alberta, and administrative approval from the Executive Management Committee of the not-for-profit caregiving organization. Related correspondence is included in Appendix A.

Setting and Subjects

Subjects in the study were chosen because of their availability; therefore, a nonprobability convenience sample was used that included registered nurses and residents in two different models of continuing care: assisted living and conventional long term care. Six registered nurses and 26 residents from four assisted living facilities

(AL_1, AL_2, AL_3, AL_4) participated, as did 13 registered nurses and 17 residents from two conventional long term care centers (LTC_1, LTC_2). All assisted living and conventional care long term care centers are operated by the same not-for-profit caregiving organization and located within metropolitan and rural areas of North Central Alberta.

The exterior and interior physical designs of the continuing care assisted living facilities and conventional long term care centers are quite different. The four assisted living facilities are relatively new, the first facility having opened in 1994 and the most recent facilities having opened in 1997, whereas the two conventional long term care centers were built in 1968 and 1973. The physical differences within the two models of continuing care are summarized in Table 3. The researcher recognizes that the differences in resident rooms, flooring, window and wall treatments, and overall physical appearance of the assisted living facilities and conventional long term care centers, may account for some differences in residents perception of autonomy within their respective care center.

Procedure for Selection of Resident Subjects

Residents were included in the study if they (a) were over the age of 65, (b) did not have a confirmed or query diagnosis of cognitive impairment, (c) had resided in their respective assisted living/conventional long term care center longer than one month, (d) were able to speak and read English, and (e) were willing to participate. To assist in identifying residents who would meet the selection criteria, a Resident Check List (Appendix B) was developed, along with a screening and selection procedure to identify residents who met the criteria for inclusion in the study. The results are presented in Table 4. In this table, $AL_{1,2,3,4}$ refers to the assisted living facilities, and $LTC_{1,2}$ refers to the conventional long term care centers participating in the study.

Table 3

Physical Features of the Assisted Living and Conventional Long Term Care Centers

	Continuing care assisted living facilities	Continuing care long term care facilities
Resident rooms	Spacious, single, apartment-style rooms which residents are encouraged to personalize with their own furnishings and personal possessions. Resident names are prominently displayed on brass door knockers. Small refrigerators are in all rooms. Residents are able to lock their rooms.	Majority of rooms are double, with a privacy curtain separating the two residents. Rooms are fairly small, and where possible, residents try to incorporate their own furnishings. Resident names are encased in plastic holders placed on the wall beside the entrance to each room. Residents are unable to lock their rooms.
Hallways	Carpet has been installed in halls and throughout the facility. Hallways are illuminated using soft lighting. Each resident has a built-in hall shelf in which to personalize and display photos, crafts, etc.	Hallways are brightly lit, and vinyl flooring has been installed in halls and throughout the center.
Furnishings	All furnishings throughout the facility are residential in design and color coordinated with carpet, window and wall treatments.	Majority of furnishings throughout the center are institutional in design and are not coordinated with the designated color palette of each care wing.
Common areas	Spacious and inconspicuous. All common areas have access to an inner courtyard	Most common areas are for multipurpose use and are fairly small. Privacy is limited.
Dining room	Spacious and often enclosed. Many windows allow natural light to brighten the room. Residents often choose what and when they would like to eat.	Spacious. Residents often dine at specified times. Residents often have minimal choice over what they eat.
Interior construction	Residential/homelike	Exposed painted brick/institutional

Table 4

Resident Check List Responses and Number of Residents Meeting Selection Criteria

Checklist screening items	AL_1 (n=30)	AL_2 (n=30)	AL_3 (n=30)	*AL_4 (n=17)	LTC_1 (n=62)	LTC_2 (n=144)
Residents over the age of 65	29 (97%)	28 (93%)	30 (100%)	6 (35%)	59 (95%)	132 (92%)
Residents having a confirmed diagnosis of cognitive impairment	11 (37%)	11 (37%)	7 (23%)	1 (6%)	17 (27%)	72 (50%)
Residents having a query diagnosis of cognitive impairment	2 (7%)	5 (17%)	7 (23%)	1 (6%)	7 (11%)	11 (8%)
Residents having resided in the center/facility for longer than one month	28 (93%)	30 (100%)	30 (100%)	15 (88%)	58 (94%)	141 (98%)
Residents able to speak and read English	27 (90%)	30 (100%)	30 (100%)	17 (100%)	59 (95%)	131 (91%)
Residents meeting selection criteria	12 (40%)	14 (47%)	12 (40%)	6 (35%)	31 (50%)	47 (33%)

*60 residents reside in AL_4 site. Of those, only 17 resident checklists were completed and returned to the researcher.

When the selection criteria were applied, a total of 122 residents were eligible to participate in the study. Of these, 44 resided in the assisted living model of care, and 78 resided in the conventional long term model of care. Thus, approximately 41% of residents in assisted living facilities and 38% of residents in conventional long term care centers met selection criteria. The majority of assisted living and conventional long term care residents were deemed ineligible to participate in the study because they had a confirmed or query diagnosis of cognitive impairment.

Procedure for Selection of Nurse Subjects

Registered nurses employed full-time, part-time, or casual were included in the study. Additional criteria required that nurses (a) be employed within their respective assisted living/conventional long term care center for more than three months (the three-month time frame ensured that nurses had completed orientation and a probationary period); (b) work in either assisted living or conventional long term care centers, but not in both; and (c) be willing to participate. No ancillary nursing personnel were included in the study.

Instruments

Measure of Resident Autonomy (Client Survey)

Documents published by Alberta Health and Wellness (1999) and the Government of Canada (1999) acknowledge that the needs of continuing care residents go beyond physical condition and include, but are not limited to, spiritual, cultural, safety, psychological, emotional, financial, and social needs. "These components are known to be important contributors to individual health status and well-being" (Alberta Health, 1999, p. 5). Alberta's continuing care system is moving toward a social model of care that is primarily resident centered and values residents' input into the planning, coordinating, and managing of services to meet residents needs (Alberta Health, 1999). A

series of demonstration and evaluation projects in Alberta have led to the development of a Client Survey designed to assess residents' perspectives of the provision of services throughout the continuing care sector (Alberta Health, 1999). The pilot test for the Client Survey involved 33 continuing care sites across Alberta, including assisted living and conventional long term care programs. The Client Survey was developed based on the vision and guiding principles for Alberta's health system and continuing care sector established by the Long Term Care Policy Advisory Committee (Alberta Health, 1999). Key principles are summarized in Figure 2.

Wellness and prevention:	Support healthy aging and emphasize health promotion and injury prevention. Assist individuals with chronic illnesses to remain independent and function to the best of their ability.
Client centered:	Maximize clients autonomy. Ensure reasonable access to affordable services. Recognize individual clients physical, psychological, spiritual and social needs. Respect and acknowledge clients right to privacy, dignity and self-determination.
Information:	Assist clients to access required and/or requested information on availability of care and services. Adhere to FOIPP guidelines.
Individual and shared responsibility	Encourage independence by assisting Albertans to reach their greatest potential, recognizing that clients have the primary responsibility for their health.

Figure 2: Guiding principles in response to an aging population (adapted from Alberta Health and Wellness, 1999).

For the purposes of this study, the Client Survey was used as a proxy measurement of resident autonomy because several items address residents' perceptions of choice, personalized care, shared decision making, privacy, respect, safety, daily routines, and independence within the respective care facility/center. These items have been identified as being important components to residents' maintaining autonomy within continuing care (Happ et al., 1996). Formal permission to use the Client Survey in this study was granted by an official of Alberta Health (Appendix A).

Reliability and Validity of Client Survey

Data analysis for the pilot study of the Client Survey involved both quantitative and qualitative measures. The Client Survey has a reported alpha reliability of 0.92, inter-item correlation ranged between 0.78 and 0.89 (Marie Lyle, personal communication, February 2000), and factor analysis indicated that there was a good fit with the majority of items (Alberta Health, 1999). Survey items and response categories were revised and reviewed by continuing care experts designated by the 17 Regional Health Authorities in Alberta. Voluntary implementation began in the fall of 1999 (Alberta Health, 1999). In its current form, the Client Survey consists of 13 required items and 10 discretionary items. The researcher was requested not to alter the wording, order of survey items, or font size. The Client Survey Instruction Sheet, Client Survey Items, and Resident Information Sheet were printed in font Arial, size 16. The six-point Likert scale response categories were printed in font Arial, size 14, and include *strongly agree, agree, neither agree nor disagree, disagree, strongly disagree*, and *does not apply*. Following common procedures for scoring Likert scales, the researcher assigned positively worded statements a value of five, to zero for *does not apply*. Reverse scoring was applied to negatively worded statements, beginning with zero for *does not apply*.

Statistical analysis of the pilot study determined that "items on the survey tend to converge on one factor and can be averaged for a total score" (Alberta Health, 1999,

p. 64). All *does not apply* responses were removed from each Client Survey questionnaire prior to the summation of scores, which was completed by hand and validated using the computer software program SPSS, student version 8.0. Summed scores were then divided by the number of items answered. This calculation was also performed by hand and confirmed using the SPSS computer software program.

Control Over Nursing Practice (CONP)

The Control Over Nursing Practice (CONP) questionnaire was developed by Dr. R. Gerber, Associate Professor, University of Arizona, School of Nursing. It is designed to measure "nursing work autonomy or control over issues within the nurse's scope of practice" (Spence Laschinger & Sullivan Havens, 1996, p. 30) and is particularly relevant for "measuring current conceptions of professional nursing practice" (p. 30). This instrument contains 21 items with a seven-option Likert scale response format. Scoring of the instrument involves summing the responses and dividing by the number of items in the questionnaire. The higher the score, the more autonomous the individual nurse feels within the workplace. The questionnaire was completed by RNs in urban and rural hospitals in Arizona who participated in the Differentiated Professional Practice Project designed to evaluate the degree to which an innovative model of professional nursing practice affects nurses' satisfaction and retention (Gerber et al., 1990). Formal permission to use the CONP questionnaire was granted by Dr. Gerber (Appendix A).

Reliability and Validity of the CONP Questionnaire

Within the Differentiated Group Professional Practice project (Gerber et al., 1990), data were collected a total of five times. CONP was found to positively influence work satisfaction (R^2=0.62) and work effectiveness. When used to measure individual perceptions of CONP, reported alpha reliabilities were ≥ 0.85 (Gerber, personal correspondence, March 1, 2000). Confirmatory factor analysis was used to estimate

construct validity. "All items loaded on a single factor (coefficient ≥ 0.40; ≥ 0.20) above any other factor loading" (Gerber et al., 1990). In addition, when CONP was factor analyzed at the same time as organizational commitment and group cohesion, the results indicate that each item loaded as conceptualized.

In a subsequent study, Wyckoff Lancero and Gerber (1995) examined nurses' control over nursing practice, job stress, and work satisfaction. Alpha reliability was reported at 0.95. Thus the CONP questionnaire has been shown to be an adequate instrument when measuring nurses' perceptions of CONP.

Conditions of Work Effectiveness Questionnaire

The Conditions of Work Effectiveness questionnaire (CWEQ) was originally developed by Rosabeth Moss Kanter (1977). Chandler (1986) was the first nurse researcher to adapt the questionnaire from Kanter's original survey to examine "nurses' perceptions of the influence of their working environments upon their personal practice power" (p. 21). In this study the CWEQ is used to measure nurses' perceptions of job-related empowerment. The CWEQ contains 32 items separated into four subscales: opportunity, information, support, and resource. The CWEQ used in this study is one of five questionnaires within the Nursing Work Empowerment Scale developed by Dr. G. Chandler and Dr. H. K. Spence Laschinger that may be used in studies of empowerment. Two items are also included as a measure of global empowerment. An overall empowerment score is achieved by summing the first four subscales. Scoring ranges from 4 to 20; the higher the score, the more empowered an individual is believed to be (Spence Laschinger et al., 1999). The CWEQ was chosen in light of its frequent use in the study of nurse empowerment. In 1992 the University of Western Ontario School of Nursing established the Kanter Power Research Program. Between 1992 and 1999 the CWEQ has been used in over 25 studies examining nursing empowerment. Formal permission to use the CWEQ was granted by Dr. Heather K. Spence Laschinger (Appendix A).

Reliability and Validity of the CWEQ

Alpha reliability coefficient for studies with the Kanter program range from 0.70 to 0.91 for the opportunity subscale, 0.73 to 0.98 for the information subscale, 0.73 to 0.93 for the support subscale, 0.65 to 0.91 for the resource subscale, and 0.81 to 0.96 for overall empowerment (Spence Laschinger, 1999).

Utilizing factor analysis, three structures emerged that were shown to influence empowerment and were identical to Kanter's original questionnaire: support, information, and opportunity (Spence Laschinger, 1996). In reports of subsequent studies involving the CWEQ, Spence Laschinger (1999) asserted that test-retest reliability is acceptable, with high scores indicating greater access to the structures of empowerment within an organization, and that face and content validity has been established by a panel of experts on Kanter's theory (Spence Laschinger, 1996, p. 30).

Data Collection Procedures

Preparation of Research Packets

Research packets containing an information letter and questionnaire(s) were prepared to facilitate data collection from the residents and nurses. Data were collected by means of three self-reported questionnaires for nurses and two self-reported questionnaires for residents. Self-reported questionnaires were chosen because they are relatively simple to administer and complete, less costly to the researcher, less invasive, and less time consuming for study subjects. The Items in the Resident Research Packet are shown in Appendix C. They are (in order):

1. Resident information letter
2. Client Satisfaction Survey
3. Resident demographic questionnaire

The items included in the Nurse Research Packet are shown in Appendix D. They are (in order):

1. Nurse information letter
2. Conditions of Work Effectiveness Questionnaire
3. Control Over Nursing Practice Questionnaire (At the written request of Dr. Gerber, only a portion of the CONP questionnaire is included in the appendix)
4. Nurse demographic questionnaire

In July 2000 the researcher met individually with the Client Services Managers and Assisted Living Coordinators in all study facilities/centers to review the purpose of the study, to invite nurse and resident involvement, and to provide a sample of nurse and resident research packets. At this time arrangements were made for nurse and resident information sessions, distribution of research packets, and completion of the Resident Check Lists. Once the dates and times for the information sessions were arranged, notices for the resident and nurse information sessions were sent to each site via interhospital mail.

Information Sessions

Throughout the months of August and September, nurse and resident information sessions were held at each site. One resident information session was held at each site. On average, 28% of the residents in each of the four assisted living facilities attended the informal information sessions. Within the two conventional long term care centers, a total of seven resident information sessions were held. Average attendance at the information sessions held in the conventional long term care centers was approximately 24%.

Nurse information sessions were held in each assisted living and conventional long term care center, and on average two nurses attended. This attendance reflects only those nurses working at the time that the information session was held. The number attending is also indicative of the small numbers of registered nurses employed within the assisted living and conventional long term care sites. An information guide (Appendix E)

was developed by the researcher to assure that consistent information was provided during all resident and nurse information sessions.

Procedure for Data Collection from Residents

Resident Check Lists were completed by RNs/Assisted Living Coordinators/ Client Service Managers for all residents within three out of four assisted living facilities and the two long term care centers. Completed resident check lists were received from five of the six sites within one to four weeks of being distributed. In one instance (site AL_4), completed resident check lists were returned 10 weeks after being distributed.

The researcher personally delivered the resident research packet to each resident identified as being eligible for the study. At the request of residents in the assisted living facilities, research packets were left on the shelf outside their doors. In the conventional long term care centers, resident research packets were handed to the residents or placed on their bed/bedside tables. If a resident was available at the time the research packet was delivered, the purpose of the study was explained.

Three weeks after distribution, a limited number of resident research packets had been returned, and the researcher had not received phone calls from residents/staff requesting assistance in completing the questionnaires. The researcher then returned to each assisted living facility once and each conventional long term care center three times to personally provide information and assistance to residents. During these follow-up visits, a total of nine residents from the long term care centers requested assistance in completing the questionnaires. Some residents had put the packet away and had forgotten about it, others were awaiting assistance, and a few were unable to complete the questionnaires on their own due to arthritis and other physical disabilities. Conscious of the need for a standardized and neutral procedure, the researcher adopted the following practice when assisting residents with the completion of the questionnaires.

1. The resident information letter was read aloud to the resident.
2. Instructions for completing the questionnaire and response categories were shown and read aloud to the resident.
3. Each question was shown to the resident and read aloud once or twice along with the response categories.
4. Once the resident verbally indicated his/her answers, the researcher circled the responses and verified with the resident that the indicated response categories had been circled.
5. If the resident did not understand or did not know how to respond, the question was left unanswered;
6. After all questions had been read aloud, the researcher placed the questionnaires in the prepaid return envelope, sealed the envelope, and dropped it in the nearest mailbox.

Procedure for Data Collection from Nurses

Once all the nurse information sessions had been held, the nurse research packets were distributed in September 2000 to AL_1, AL_2, AL_3, LTC_1, and LTC_2 sites. Research packets to AL_4 site were distributed in November 2000 due to the extended period of time taken to return completed resident check lists. Research packets were attached to the nurses' pay stubs and distributed through the payroll department of the study organization.

CHAPTER 4

RESEARCH FINDINGS

This chapter contains three sections in which the research findings from the study are presented. The first section provides detailed descriptive findings of the study subjects. Nurse and resident response rates are discussed in the second section. Analytical research findings related to each research objective and the statistical methods employed are discussed in the third section. SPSS student version 8.0 was the computer program used for data analysis.

Residents' Demographic Data

Residents in the four assisted living and two conventional long term care study sites were requested to respond to four demographic questions. Information pertaining to gender, age, length of residence, and type of center was obtained. The frequency and percentage distribution of demographic data obtained from continuing care assisted living residents are displayed in Table 5.

Discussion of Resident Demographic Data

As shown in Table 5, the vast majority of assisted living and conventional long term care respondents were female, which is not unexpected, considering that Alberta's female senior population consistently outnumbers its male counterparts (Statistics Canada, 1999; as cited in Alberta Community Development, 2000); and from data collected in 1990 by Smith, Schalm, Shaw, Wellock, and Lyle (1991), who reported that approximately 66% of Alberta's long term care residents were female. From demographic data gathered by the not-for-profit organization on all residents in the four assisted living facilities, it appears that 77%-90% of residents in each facility are female. In this study, nearly 47% of respondents from each model of continuing care fell within the age range of 75 and 84, higher than the 32.9% provincial distribution. More than one

Table 5

Frequency and Percent Distribution of Demographic Data From Conventional Long Term Care Residents (n=17) and Assisted Living Residents (n=26)

	Conventional long term care		Assisted living	
Data	Frequency	Percentage	Frequency	Percentage
Gender				
Female	14	82.4	22	84.6
Male	3	17.6	4	15.4
Age				
65-74	0	0.0	2	7.7
75-84	8	47.1	12	46.2
85-94	8	47.1	9	34.6
95+	1	5.9	2	7.7
Missing data			1	3.8
Length of residence				
< 1 year	4	23.5	5	19.2
1-3 years	5	29.0	15	57.7
3-5 years	2	12.0	4	15.4
> 5 years	3	17.6	1	3.8
Missing data	3	17.6	1	3.8

half (57.7%) of the residents in the four assisted living facilities had lived there between one and three years. This range of years of residence was also the most frequent in conventional long term care centers (29%).

Nurses' Demographic Data

Registered nurses were requested to respond to seven demographic questions. Information on the type of center, gender, age, employment status, years of employment, hours worked, and education level was obtained. Table 6 displays demographic data gathered from assisted living and conventional long term care nurses.

Discussion of Nurses' Demographic Data

In 1999, 228,450 registered nurses were practicing in Canada (Canadian Nurses Association [CNA], 2000), with the majority employed in acute care facilities. Within the past five years, statistics show a movement of nurses from acute care to various other health care settings, such as conventional long term care centers. In 1994 continuing care registered nurses accounted for 10.8% of all practicing nurses in Canada, and by 1999 that figure had risen to 11.7% (CNA, 2000).

The Canadian Nurses Association (2000) reported in 1999 that 45.3% of practicing nurses worked part-time, and in this study 46.2% of nurses in the conventional long term model of care and 50% of nurses in the assisted living model of care were part-time employees. In addition, 46.2 % of nurses working in the conventional long term care centers and 50% of the nurses working in assisted living reported having worked in their respective care centers less than five years. This may reflect the movement of nurses into continuing care. Furthermore, the continuing care sector is rapidly changing, and numerous innovative residential care models began emerging around 1994. This may also have contributed to the overall increase in continuing care nurses.

The nursing profession is faced with an aging workforce in which, currently, the average age of a Canadian nurse is 43. As displayed in Table 6, being in the age group

Table 6

Frequency and Percent Distribution of Demographic Data From Continuing Long Term Care Nurses (n=13) and Assisted Living Nurses (n=6)

Data	Conventional long term care		Assisted living	
	Frequency	Percentage	Frequency	Percentage
Gender				
Female	13	100.0	6	100.0
Age				
21-30	2	15.4	1	16.7
31-40	2	15.4	1	16.7
41-50	5	38.5	3	50.0
51-60	2	15.4	1	16.7
> 60	1	7.7	0	0.0
Missing data	1	7.7		
Employment status				
Full-time	5	38.5	2	33.3
Part-time	6	46.2	3	50.0
Casual	2	15.4	0	0.0
Missing data			1	16.7

(table continues)

Data	Conventional long term care		Assisted living	
	Frequency	Percentage	Frequency	Percentage
Years of employment in current center/facility				
< 5 years	6	46.2	3	50.0
5-10 years	1	7.7	2	33.3
11-15 years	1	7.7	0	0.0
> 15 years	2	15.4	0	0.0
Missing data	3	23.1	1	16.7
Hours worked per week				
< 20	1	7.7	2	33.3
20-30	2	15.4	0	0.0
30-40	6	46.2	2	33.3
> 40	3	23.1	1	16.7
Missing data	1	7.7	1	16.7
Nursing education				
RN	8	61.5	3	50.0
BScN (BN)	4	30.8	2	33.3
MN and master's in other field	0	0.0	1	16.7
PhD	0	0.0	0	0.0
Missing data	1	7.7		

41-50 was most often reported among nurses in the two models of care (Long Term Care: 38.5%; and Assisted Living: 50%). The Canadian Institute for Health Information ([CIHI], 2000) recently disclosed that the number of nurses entering the workforce with baccalaureate degrees is 11.1%, up 2.7% over the past five years. Considering an aging work force and professional standards, the majority of nurses within the two conventional long term care centers (61.5%) and four assisted living facilities (50%) in the study cited a nursing diploma as their highest level of education, slightly lower than the national average of 76%.

Nurses in Alberta represent 9.7% of all practicing nurses in Canada. Of these practicing nurses in Alberta, 34% reported having a baccalaureate degree (Susan Lynch, Alberta Association of Registered Nurses, personal communication, February 2001). This percentage is higher than the national rate of 22.2% (CIHI, 2000). In this study nurses having a baccalaureate degree represented 30.8% of respondents from the conventional long term model of care and 33.3% of respondents from the assisted living model of care.

Response Rates

As discussed in Chapter 3, 44 (41%) assisted living residents were identified as being eligible to participate in the study. Although 78 (38%) conventional long term care residents were initially identified as being eligible to participate, only 72 (35%) received research packets because one resident was too ill to complete the questionnaires, one resident had died, and four residents stated that they were not interested in participating in the study. In total, 116 residents in the two models of continuing care received research packets. Fifty (43%) research packets were returned from residents in the two models of continuing care, constituting an overall response rate of 43%. The response rate from residents in the two conventional long term care centers was 24%, with 17 research packets returned; and residents in the four assisted living facilities achieved a response rate of 59%, with 26 research packets returned. This difference in resident response rates

alerted the researcher to a possible response rate bias. This may affect study findings and must be considered as the findings are interpreted. Seven of the returned research packets were not used in the study because they were not completed. Thus only 37% of the resident research packets returned were actually utilized in the study.

Discrepancies in the demographic data gathered from residents in the two models of continuing care may account for the difference in resident response rate. Current information about resident characteristics in the four assisted living facilities was obtained from the not-for-profit organization. Within the assisted living model of care, a difference in the number of responses in two of the four age ranges is apparent. As shown in Table 5, 46.2% of respondents were within the age range 75-84, and 34.6% were within the age range 85-94. This discrepancy accounts for 11.6% of the variation in response rate for this category and possibly reflects the larger proportion of residents in assisted living between the age range 75 and 84 who are willing to participate in a study. Assisted living residents in the age range 85-94 may have participated in a number of previous studies having been conducted in this innovative model of care and therefore declined to participate in yet another study. Respondents from the assisted living model of care may also not be representative in terms of age, because it appears from the data gathered by the not-for-profit organizations that 28% of residents in this model of care are less than 65 years of age; 13% are between 65 and 74; 24% are between 75 and 84; 29% are between 85 and 94; and 6% are 95 or older.

Data regarding health and mental status and care requirements were not collected in the study. The possibility of selection bias within the two models of continuing care may account for the differences in resident response rates. Residents in the conventional long term model of care are likely to be more medically complex or have greater disabilities than the majority of residents in assisted living. They may therefore require more assistance in completing the questionnaires and for this reason may have chosen not

to participate. It may also be the case that residents in conventional long term care perceive a lack of privacy and/or fear of retribution, therefore declining to participate.

Length of residence in both models of continuing care was another category in which differences were identified, possibly affecting response rates. A 42% variation in response rate was identified among assisted living residents residing 1-3 years and 3-5 years. In the conventional long term model of care, a variation of 17% was noted among residents residing 1-3 years and 3-5 years. Perhaps these findings suggest that residents residing 1-3 years are more willing to express their views and opinions by participating in studies than residents new to the center or those residing longer than three years are.

Based on selection criteria outlined in Chapter 3, 24 nurses from the assisted living model of care and 45 nurses from the conventional long term model of care were identified as being eligible to participate in the study and received research packets. As nurses were eligible to participate based on whether they worked in assisted living or conventional long term care, the possibility of selection bias among nurses in these two models of continuing care is recognized and is a factor to consider that may affect response rate and findings. Twenty research packets were returned, resulting in a response rate of 29%. Of the 20 nurse research packets returned, 19 were used in the study. One respondent worked in both assisted living and conventional long term care and therefore did not meet selection criteria. The response rate from nurses in the conventional long term model of care was 29%, with 13 research packets returned; and nurses in the assisted living model of care achieved a 25% response rate, with six research packets returned. As these response rates are considered to be fairly low, the researcher recognizes the possibility of a biased response rate among nurses in the two models of continuing care. However, this may be offset from data collected by the not-for-profit organization in which these nurses appear to be representative of the nurses in each model of care in terms of gender, employment status, years of employment in current facility, and education.

In both models of continuing care, differences in demographic data may account for differences in response rates of nurses. In the assisted living model of care, 50% of respondents were within the age range 41-50, whereas 16.7% were within age ranges 21-30, 31-40, and 51-60. This difference accounts for 33% of the variation in response rate in the age category. A similar difference is noted among conventional long term care nurses, as 38.5% of respondents were within the age range 41-50 and 15.4% were within the 21-30, 31-40, and 51-60 age ranges. This difference accounts for 23% of the variation in response rate for the age category. This finding suggests that there may be a greater number of nurses in the two models of continuing care between ages 41-50 than any other age range.

In both models of continuing care, discrepancies in employment status are noted. Among assisted living nurses, 16.7% more were employed part-time than were employed full-time; and in conventional long term care, 7.7% more were employed part-time than were employed full-time. This finding is likely indicative of a larger proportion of part-time nurses. Among assisted living nurses, a difference is noted in length of employment in the current facility, as 17% more nurses acknowledged having worked less than 5 years than those employed between 5-10 years.

Differences in nursing education might also be a factor affecting response rates. In assisted living there were 17% more nurses having an RN diploma than those having a baccalaureate degree. In the conventional long term model of care, this difference accounts for 33% of the variance among nurses with an RN diploma and those with a baccalaureate degree.

In this study, nurses in the age range 41-50, employed part-time, employed less than five years, and having an RN diploma were more likely to respond to the questionnaires than nurses in all other categories.

Analytical Research Findings and Discussion

The study was undertaken to describe and explore nurses' perceptions of empowerment and autonomy and residents' perceptions of their own autonomy within two models of continuing care: assisted living and conventional long term care. Six research objectives guided the development and implementation of the study. Analytical findings and discussion of findings related to each research objective are now presented.

Research Objective #1

To describe and explore the perceptions of empowerment among nurses in two models of continuing care: assisted living and conventional long term care.

The means, range, and standard deviations of nurses' perceptions of job-related empowerment derived from the CWEQ are presented in Table 7.

Table 7

Means and Standard Deviations of Nurses' Perceptions of Job-Related Empowerment

Continuing care model	n	Range	Mean	SD
Assisted living	6	10.36-13.58	12.57	1.88
Conventional long term care	13	7.89-13.58	11.58	1.94

Score range: 4-20

In this study conventional long term care nurses' perceptions of job-related empowerment are comparable to those in previous studies involving nurses in acute care environments. Spence Laschinger (personal correspondence, October 31, 2000) interpreted overall empowerment scores in the range of 10-11 as moderate. Therefore, scores below 10 may be interpreted as low to moderately low, and scores above 12 may

be interpreted as moderately high or high. Studies by Spence Laschinger and Shamian (1994), Sabiston & Spence Laschinger (1995), Spence Laschinger and Sullivan Havens (1996), and McDermott et al. (1996) revealed that empowerment scores among nurses in various acute care settings were moderate and ranged from 10.90 (SD=2.62) to 11.65 (SD=2.21). Within this study, mean empowerment scores among nurses in the conventional long term model of care (M=11.58; SD=1.97) are lower than the empowerment scores among nurses in the assisted living model of care (M=12.57; SD=1.88). These findings as well as the findings from previous studies may indicate that nurses in acute and conventional long term care perceived that there are barriers to their ability to access the sources of empowerment or that the sources of empowerment were not available to them.

Differences in empowerment scores within the two models of continuing care may be explained by a 1997 study by Beaulieu et al. These researchers examined registered nurses', registered practical nurses', and front line managers' perceptions of empowerment in two long term care centers. Registered nurses in one center perceived that they possessed a moderately low degree of empowerment (M=9.53; SD=2.50), whereas registered nurses in the other long term care center had a mean empowerment score of 12.1 (SD=2.42). Results were explained citing Kanter's (1977) proposition that "employees who perceive their managers as upwardly and outwardly influential, perceive their own status to be enhanced by association" (p. 36). Perhaps assisted living nurses perceived that they were more empowered because they perceived that their immediate supervisor possessed a great deal of leadership and power within the organization. Although not explored in this study, nurses' workload, roles, and responsibilities; staff mix; and managerial leadership may also account for differences in nurses' perception of empowerment within the two models of care. Furthermore, assisted living nurses may perceive that they have greater flexibility in their jobs, thus allowing them better access to the sources of empowerment and the use of creativity and discretion in decision

making. In addition, assisted living nurses' knowledge and ability to reinforce the principles of assisted living (independence, privacy, respect, choice, individuality, and a homelike environment) may enhance their overall sense of empowerment. According to Kanter, an individual's perception of empowerment evolves from formal and informal organizational structures, and those believing that they possess greater access to formal and informal power will most likely perceive themselves to be more empowered. Although this relationship was not tested in the study, it is possible that assisted living nurses believed that they possessed greater access to formal and informal power than conventional long term care nurses did, which would account for the difference in empowerment scores. Furthermore, the range of responses among nurses in the two models of continuing care may also account for the difference in the overall empowerment score among nurses in the two models of continuing care.

It is also possible that the differences in demographic variables such as age, employment status, years of employment in current center/facility, hours worked per week, and education level affect nurses' overall perception of empowerment. However, testing for such differences was beyond the scope of this study. In the literature, the effect/relationship of demographic variables on nurses' perceptions of overall empowerment (all subscales combined) has been reported infrequently and inconsistently. Studies by Sabiston and Spence Laschinger (1995), Spence Laschinger and Shamian (1994), and Chandler (1991) did not reveal statistically significant differences between demographic variables (age, experience, and education) and overall perceptions of empowerment. Sabiston and Spence Laschinger (1995) revealed that a statistically significant difference was identified between area of practice and overall job-related empowerment. Their study was conducted in acute care and involved nurses from medical/surgical and critical care areas. Although such testing was beyond the scope of this study, testing the differences or relationships between model of continuing care and job-related empowerment may reveal statistically significant differences.

To date, minimal research has been conducted examining empowerment among nurses in continuing care, and prior studies of nurses' perceptions of job-related empowerment have not been conducted in assisted living or other innovative models of care. Further research in this area would be useful.

Research Objective #2

To describe the perceptions of autonomy among nurses in two models of continuing care: assisted living and conventional long term care.

The means, range, and standard deviations of nurses perceptions of autonomy, derived from the CONP questionnaire, are shown in Table 8.

Table 8

Means and Standard Deviations of Nurses' Perceptions of Autonomy

Continuing care model	n	Range	Mean	SD
Assisted living	6	4.71-6.38	5.81	0.29
Long term care/ conventional care	13	1.71-6.90	4.82	1.49

Score range: 1-7

The higher mean scores among nurses in assisted living (M=5.81; SD=0.29) suggests the possibility that these nurses perceived themselves to be more autonomous. Interestingly, however, the highest score for autonomy was reported by a nurse in the conventional long term model of care. The low score of 1.71 within the conventional long term model of care may account for the lower mean score among these nurses. Nurses in both models of care achieved higher scores than those of nurses in a previous study involving acute care staff nurses (M=4.46; SD=1.12; Spence Laschinger, 1996).

One of the unique qualities of the assisted living model of care is the principles of assisted living, which nurses and residents are encouraged to support. Thus, the role of an assisted living nurse is that of an enabler, and perhaps his/her knowledge of and ability to foster these principles and encourage residents to remain as independent as possible contributed to their overall sense of workplace autonomy. In addition, the fact that assisted living nurses perceived that they had greater access to empowerment structures may be an influencing factor in their perception of autonomy. On the other hand, long term care nurses' empowerment and autonomy scores may indicate that these nurses require greater access to empowerment structures before they can acquire greater control over their nursing practice (Sabiston & Spence Laschinger, 1995). The relationship between empowerment and autonomy was not examined in this study, but the findings may provide support for Kanter's (1977) proposition that access to empowerment structures enables staff to exercise greater autonomy in the workplace. Findings from studies by Spence Laschinger and Sullivan Havens (1996) and Sabiston and Spence Laschinger (1995) support Kanter's proposition.

Differences on demographic variables may also affect nurses' perceptions of autonomy. A study by Sabiston and Spence Laschinger (1995) examining staff nurses' perceptions of empowerment and autonomy revealed that the demographic variable "years in current practice area was weakly related to perceptions of autonomy" (p. 48). This finding was interpreted to suggest that the degree of acquaintance with a practice area may increase autonomy or control over nursing practice (Sabiston & Spence Laschinger, 1995). Testing the relationship between demographic variables and autonomy was beyond the scope of the study.

Research Objective #3

To describe the similarities and differences in the perceptions of empowerment and autonomy among nurses in two models of continuing care: assisted living and conventional long term care.

Among nurses in the two models of continuing care, the mean scores obtained from individual items on the CWEQ were similar on 15 of the 32 items, with nurses from the four assisted living facilities achieving higher means on 27 of the 32 survey items. Sixteen items were found to have mean score differences of >.40. One item was from the information subscale, three items were from the opportunity subscale, six items were from the support subscale, five were from the resource subscale, and one was from the global empowerment subscale. These differences were not statistically significant. However, they are of clinical relevance and suggest that managers of continuing care centers take the opportunity to review organizational structures and managerial and leadership practices that may be perceived by staff as barriers, as well as the opportunity to review and/or implement strategies aimed at increasing nurses' access to the sources of empowerment.

Only one item on the CWEQ had a statistically significant mean difference at alpha level .05. T-test results indicate that nurses in assisted living (M=4.00; SD=0.63) and conventional long term care (M=2.77; SD=0.83; t=3.203; p=.005) perceived differences in their work environments that were statistically significant. The majority of items on the CWEQ, including overall empowerment, were found to be statistically nonsignificant. This finding may reflect the small sample size and power level (.36).

Mean scores obtained from individual items on the CONP questionnaire were lower among nurses in the conventional long term model of care, whereas assisted living nurses achieved higher scores on all but one survey item. Conventional long term care nurses perceived that they had greater freedom to coordinate care activities among

various health services (M=4.54; SD=2.17) than was perceived by assisted living nurses (M=4.33; SD=1.86). This is consistent with the principles of assisted living because nurses are more likely to collaborate, and to support and encourage residents to seek out and access available health services.

The evaluation of current nursing policies and procedures was the only item on the CONP questionnaire in which a statistically significant mean difference was identified. This finding may also be due to small sample size and power level (.36). T-test findings indicate that conventional long term care nurses perceived that they were less free to evaluate current nursing policies and procedures (M=2.92; SD=1.90) than were assisted living nurses (M=5.17, SD=0.75; t=2.77, p=.013). Other items identified as not having statistically significant mean differences may indicate that nurses in the conventional long term model of care require greater independence in decision making and accountability for decisions made affecting resident care practices. In addition, organizational structures might require review if staff perceive the presence of barriers as affecting their ability to remain autonomous.

Results from the means and t-test on nurses' perceptions of empowerment and autonomy may indicate trends among nurses in the two models of continuing care. As shown in research objective #1, nurses in assisted living achieved higher mean sores, suggesting that they perceived themselves to possess greater access to empowerment structures in the workplace than did conventional long term care nurses. Assisted living nurses' responses in relation to research objective #2 indicate that they perceived themselves to possess greater control over their nursing practice than nurses in conventional long term care did. Assisted living nurses also agreed more often than their counterparts in conventional long term care did that their working environments empowered them to accomplish their work in an effective and efficient manner and that they had the freedom to evaluate current nursing policies and procedures. A reverse trend is apparent among long term care nurses, who perceived that there may be barriers to

their ability to access the sources of empowerment and perceived themselves to have less control over their working environment. These nurses also perceived that their working environment did not empower them to accomplish their work in an effective manner, and they did not feel that they were able to freely evaluate current nursing policies and procedures.

As explained earlier, the theoretical basis of the CWEQ is Kanter's (1977) theory of structural power, and one of Kanter's propositions states that individuals who perceive that they have greater access to informal and formal power structures and empowerment sources are likely to be more autonomous and, consequently, more effective within the work place. Although this study was not designed to directly test Kanter's theory, the findings appear to support this proposition. In addition, evaluating nursing policies enables nurses to direct and be accountable for the delivery of evidence-based nursing care practices and often results from supportive organizational and managerial leadership structures. These factors may have contributed to the overall sense of empowerment reported by assisted living nurses. Further studies of nurses in conventional long term care and assisted living or other innovative care environments should include measurement of factors such as organizational culture and managerial leadership, with variables such as nursing satisfaction, decision making, and work effectiveness within the two models of continuing care.

Research Objective #4

To analyze the differences, if any, of nurses' scores on the opportunity, information, resource, and support subscales as measured by the CWEQ questionnaire within the two models of continuing care: assisted living and conventional long term care.

The trend toward higher empowerment and autonomy scores among assisted living nurses and lower empowerment and autonomy scores among conventional long term care nurses is once again apparent in the nurses' responses on the four subscales of

the CWEQ's four subscales. Assisted living nurses achieved higher scores in three of the four subscales. The means and standard deviations of the CWEQ subscales are shown in Table 9. It appears that nurses in the four assisted living facilities perceived themselves to possess greater access than did the conventional long term care nurses on three of the four subscales: information, support, and resource. Conventional long term care nurses had a mean of 3.42 (SD=0.63) in the opportunity subscale, scoring only slightly higher than did nurses in assisted living (M=3.38; SD=0.84)). The lowest mean score among nurses in the assisted living facilities occurred in the information subscale, whereas the lowest mean score among nurses in conventional long term care occurred in the resource subscale. The highest mean scores in both models of care occurred in the opportunity subscale, consistent with previous studies. The results from the t-test reveal that the coefficient (p) for the opportunity subscale is 0.93, information subscale is 0.92, support subscale is 0.24, and resource subscale is 0.06. Thus, no statistically significant mean

Table 9

Means and Standard Deviations of the CWEQ Subscales Among Nurses in the Two Models of Continuing Care

Subscale	Continuing care model	n	Range	Mean	SD
Information	Assisted living	6	1.43-4.00	2.95	.90
	Conventional long term	13	1.29-4.14	2.91	.80
Opportunity	Assisted living	6	2.29-4.43	3.38	.84
	Conventional long term	13	2.29-4.57	3.42	.63
Support	Assisted living	6	2.67-3.89	3.26	.46
	Conventional long term	13	1.44-4.00	2.84	.78
Resource	Assisted living	6	2.43-3.86	2.98	.51
	Conventional long term	13	1.71-4.00	2.42	.60

Score Range: 1-5

differences were identified among the four subscales. Interestingly though, the highest and lowest response range scores within the four subscales occurred in the conventional long term model of care. The greatest difference in mean scores among nurses in the two models of continuing care occurred in the support and resource subscales, which may signify clinical relevance in enhancing nurse empowerment among conventional long term care nurses.

The concept of assisted living is guided by a set of principles, and it may be that nurses in assisted living perceive that these principles and the organizational structures, management practices, and leadership required to implement them, enables them as professionals to exercise greater discretion, flexibility, and creativity in decision making. This in turn may contribute to residents' sense of autonomy.

Recognizing the mean differences (although not statistically significant) among nurses in the two models of continuing care provides managers and health care providers the opportunity to review the barriers that may be present that affect nurses' ability to fully access the four empowerment subscales and the opportunity to implement strategies aimed to improve empowerment in the workplace and enhance the quality of nurses' worklife and quality of care. Demographic variables such as age, employment status, and education level among nurses in the two models of continuing care may also affect perceptions of empowerment. However, such testing was beyond the scope of the study.

Research Objective #5

To describe the perceptions of autonomy among residents in two models of continuing care: assisted living and conventional long term care.

The means, range, and standard deviations of residents' perceptions of their own autonomy, derived from the Client Survey, are shown in Table 10.

Table 10

Means and Standard Deviations of Residents' Perception of Autonomy

Continuing care model	n	Range	Mean	SD
Assisted living	26	3.20-5.00	4.20	0.43
Long term care/ conventional care	17	3.05-4.46	3.68	0.40

Score range: 1-5

The higher mean score of residents in assisted living suggests the possibility that these residents perceive themselves to be more autonomous.

Dependency and a state of oppression often result when residents who once were homeowners, providers of families, parents, and family decision makers relinquish much of the control over their lives upon admission to continuing care centers (Tolley, 1997). Residents' overall perception of autonomy in the two models of continuing care may be different due to factors that residents view as either compromising or enhancing their autonomy.

The principles of assisted living may be one factor responsible for the higher mean score among assisted living residents, because they are encouraged to make choices regarding the amount of privacy they want, the routines they like, the degree of participation in activities, what and when to eat, and the number of services available to them. These residents are free to come and go as they please and are less likely to be told what to do and when to do it, which may not be the case in conventional long term care centers. It may be that residents in conventional long term care centers view the adherence to rules such as specified meal, bed, and bath times as compromising their sense of autonomy (Browne, 2001). The ability of assisted living and conventional long term care residents to live at risk may be perceived as either compromising or enhancing

residents' sense of autonomy, as well as the status of residents' physical and mental health, the perception of the "burden of care," and the architectural design of their respective care center (see Table 3). According to Bronfman (1994), the majority of older adults facing admission to continuing care centers are saying, "Don't put me next to someone I don't even know, with florescent lights over my head and a cold linoleum floor, and come crashing into my room anytime you want and tell me to play Bingo" (p. 61). In addition, unlike assisted living residents, who are encouraged to bring their own furniture upon admission, conventional long term care residents are restricted as to what they can bring because space is limited, and this may be seen as a compromising factor to their autonomy.

Differences in age range and length of residence on the demographic data gathered from residents in the two models of continuing care may also account for the differences in perception of autonomy. Furthermore, the difference in perception of autonomy may be due to selection bias and/or response rate bias and should be considered in the context of the findings. One other factor to be considered, but not tested in the study, is that residents' perception of autonomy may be related to nurses' perceptions of autonomy in the workplace.

Research Objective #6

To describe the similarities and differences in the perceptions of autonomy among residents in two models of continuing care: assisted living and conventional long term care.

Residents in assisted living scored higher that conventional long term care residents on all survey items. Mean scores obtained from the individual items on the Client Survey were comparable within the two models of continuing care on 11 of the 23 survey items. An independent sample t-test was performed, and 12 survey items were identified as having statistically significant mean differences at alpha level .05. However,

there may be power problems in detecting statistical significant in residents' perceptions of autonomy in the two models of continuing care due to the small sample size.

Within recent years, the shortage of long term care beds in Alberta has meant that individuals assessed as requiring continuing care services have had to wait longer to receive these services; and, as echoed in this study, the time that residents waited to be admitted to their respective care center was significantly less acceptable among conventional long term care residents (M=3.13; SD=1.31) than among assisted living residents (M=4.15; SD=.61; t=3.46; p=.001).

Differences in residents' perception of the components comprising personalized care were found to be statistically significant. Conventional long term care residents' perception that staff worked with them to meet their needs was significantly less (M=3.93; SD=.46) than that of assisted living residents (M=4.42; SD=.50; t=3.097; p=.004).The perception that staff take into account residents' likes and dislikes when providing care was found to be significantly less among conventional long term care residents (M=3.53; SD=.87) than among assisted living residents (M=4.36; SD=.57; t=3.74; p=.001). Similarly, the perception that staff helped residents to keep the daily routines that they preferred was significantly less among residents of the two conventional long term care centers (M=3.88; SD=.62) than among residents of the four assisted living facilities (M=4.32; SD=.48; t=2.60; p=.013). In addition, conventional long term care residents' perception that staff responded promptly when they needed help was significantly less (M=3.42; SD=1.18) than that perceived by assisted living residents (M=4.04; SD=.72; t=2.17; p=.036).

The perception that staff tell residents what they want to know about their health and medical condition was significantly less among conventional long term care residents (M=3.44; SD=1.15) than among assisted living residents (M=4.18; SD=.80; t=2.36; p=.024). Likewise, the perception that staff tell residents about the care and services available to them was significantly less among conventional long term care residents

(M=2.94; SD=1.39) than among assisted living residents (M=4.04; SD=.60; t=3.57; p=.001), an indication that conventional long term care residents perceived that the lack of information regarding their health and availability of care and services are barriers to their ability to remain autonomous.

The perception that residents were getting care in their preferred location was found to be significantly less among residents of the two conventional long term care centers (M=3.56; SD=1.15) than among residents of the four assisted living facilities (M=4.24; SD=.88; t=2.130; p=.040). Similarly, residents of the two conventional long term care centers were found to be significantly less satisfied with the services they received (M=3.82; SD=.73) than were residents of the four assisted living facilities (M=4.42; SD=.58; t=3.00; p=.005). These results may provide evidence for areas of improvement in the provision of services within conventional long term care centers.

Conventional long term care residents perceived that they were significantly less able to afford the health services that they paid for (M=2.93; SD=1.27) than their counterparts in assisted living were (M=4.42; SD=.58; t=3.00; p=.005). Residents of the two conventional long term care centers were found to disagree less often that staff did not allow them to do as much as they could for themselves (M=3.44; SD=1.21) than residents of the four assisted living facilities were (M=4.12; SD=.68; t=2.30; p=.027). In addition, conventional long term care residents disagreed less often that they did not feel safe with staff at all times (M=3.24; SD=1.25) than did assisted living residents (M=4.13; SD;1.08; t=2.44; p=.019). Once again, these findings are not only statistically significant, but also are important in terms of assessing residents' ability to afford needed services and may provide support for the premise that one's environment influences his/her perception of autonomy.

Of the 12 survey items having statistically significant mean differences, four survey items pertained to the individual components of autonomy. Two items pertained to individualized care: "Staff take into account my likes and dislikes when they provide

my care" and "Staff help me keep the daily routines I prefer." One item pertained to independence: "Staff do not allow me to do as much as I can for myself," and the last item pertained to safety: "I do not feel safe with the staff at all times." Overall, residents in the four assisted living facilities consistently scored higher and were ultimately more satisfied with where they resided than were residents in the two conventional long term care centers.

Once again, the principles of assisted living—individuality, independence, safety, and a homelike environment—may contribute to the differences in perception, because these principles are imbedded in the assisted living philosophy and supported by management and staff. In addition, the two models of continuing care promote a social model of care as well as resident-centered care, and it may be the manner in which the concept of resident centered care is interpreted as well as the extent to which it is implemented that accounts for differences in residents' perception of autonomy. It is also possible that residents in conventional long term care centers who perceived that staff only moderately (M=3.93; SD=0.46) helped them meet their needs and remain independent, only moderately (M=3.53; SD=0.87) took into account their likes and dislikes when providing care, and only moderately (M=3.87; SD=0.62) helped them keep their daily routines internalized these factors as compromising to their individuality, independence, and right to remain autonomous. In this study, the mid-point value of 3 is interpreted as moderate. Residents' knowledge of nurses' workload and perception of burden of care may contribute to residents' feeling that staff do not take the time to personalize care or maintain routines preferred by residents. In addition, conventional long term care residents may perceive adherence to rules, sense of dependency, and inadequate participation in decision making as barriers to their autonomy. As echoed in this study, conventional long term care residents acknowledged that they want to know more about the status of the health and medical condition and availability of care and services. Statistically significant mean differences on these items on the Client Survey

may be due to the fact that assisted living residents often have greater contact with their own physicians, and make and attend physician appointments, thereby ensuring that they are able to directly voice concerns and questions. Furthermore, nurses in assisted living may provide more support and encouragement for residents to participate in the direction of their care and may possess greater knowledge of the variety of care and services available to residents.

The finding that conventional long term care residents perceived that they were less able to afford the services for which they paid may be an indication that they have less access to a social worker to assist with their finances and provide information on services that are available to them, or it may be they are not in control of their finances and therefore do not know what services they can and cannot afford.

Although not examined in this study, residents' perception of their environment as being homelike or institutional and the physical features of both models of care shown in Table 3 may be additional factors contributing to their sense of safety, autonomy, and quality of life.

Last, the response rate from residents in the assisted living model of care was greater than the response rate from residents in the conventional long term model of care, which may have contributed to the significant differences in perception of autonomy.

Summary of Findings

The findings in the study indicate that, based on mean scores, nurses in the conventional long term model of care (M=11.58; SD=1.94) may perceive themselves as having less access to the sources of empowerment, whereas nurses in the assisted living model (M=12.57; SD=1.88) may perceive themselves as having greater access. Conventional long term care nurses achieved a lower autonomy mean score (M=4.82; SD=1.49), suggesting that they perceive themselves to be less autonomous in the workplace than their counterparts in assisted living (M=5.81; SD=0.29). Residents in the

conventional long term model of care had lower autonomy mean scores (M=3.68; SD=0.49), suggesting that these residents may perceive themselves to be less autonomous. These findings suggest the need for further studies to examine possible barriers to empowerment and autonomy of nurses and residents in conventional long term and assisted living models of care.

Kanter's (1977) theory of structural power in organizations was the basis for development of the instrument used to measure empowerment and autonomy of nurses in this study. Although the study was not designed to directly test this theory, the findings add to the body of published research on nurse empowerment and autonomy.

Differences in nurses' perceptions of empowerment were explained by citing several of Kanter's (1977) propositions. According to Kanter, an individuals perception of empowerment evolves from formal and informal organizational structures, and those believing that they possess greater access to formal and informal power will most likely perceive themselves to be more empowered. Although this relationship was not tested, this proposition may account for the difference in nurse empowerment scores.

The higher mean score of nurses in assisted living suggest that they may perceive themselves to be more empowered because they perceived that their immediate supervisor possessed a great deal of leadership and power within the organization, whereas the opposite may be true of conventional long term care nurses. This finding provides support for Kanter's (1977) proposition that "employees who perceive their managers as upwardly and outwardly influential, perceive their own status to be enhance by association" (p. 36). The relationship between empowerment and autonomy was not examined in this study, but the findings may provide support for Kanter's (1977) proposition that access to empowerment structures enables staff to exercise greater autonomy in the workplace.

CHAPTER 5

LIMITATIONS, IMPLICATIONS FOR HEALTH CARE PROVIDERS, AND RECOMMENDATIONS FOR FUTURE RESEARCH

In this chapter the limitations of the study, implications for health care providers, and recommendations for future research are discussed.

Limitations

The two conventional long term care centers and four assisted living facilities were purposely selected because they are operated by the same not-for-profit caregiving organization. These sites may not be representative of other conventional long term care centers and assisted living facilities.

Residents were included in the study if on the basis of self-reporting they (a) were over the age of 65, (b) had resided in their respective care center for longer than one month, (c) did not have a confirmed or query diagnosis of cognitive impairment, (d) were able to speak and read English, and (e) were willing to participate. Nurses were included in the study if they (a) were employed full-time, part-time, or casual; (b) were employed in their respective care center longer than three months; (c) worked in either assisted living or conventional long term care, but not in both; and (d) were willing to participate.

All residents in the two conventional long term care centers and four assisted living facilities were eligible to participate, and the residents meeting the inclusion criteria for this study may not be representative of the continuing care population in general. All were identified as being eligible for and in need of continuing care services by the Central Assessment and Placement Services (CAPS) in the Capital Health and Westview Regional Health Authorities. This process by CAPS ensures that individuals requiring continuing care services are placed in the program that best meets their needs (Good Samaritan Society, 1999). Although health and mental status, and classification level were not examined in this study, it can be assumed that because of the CAPS

process, residents in the study required a sufficient level of social support and health care to be admitted to facility-based continuing care.

Nurses in the two models of continuing care may also not be representative of other nurses in the centers/caregiving organization. However, they were representative of practicing nurses in Canada in regards to their age, gender, education, and employment status and within their models of care in regards to their gender, employment status, and education. As the respondents may not be representative of nurses in the continuing care sector, the findings may not be generalizable beyond the two subject groups.

There may also be differences in philosophy of care, organizational culture, and management practices across the two assisted living and four conventional long term care centers. These differences were controlled in some respects in this study because all assisted living and conventional long term care sites are operated under the same organizational auspices. However, it was beyond the scope of this study to explore organizational characteristics, so these may vary between the organization operating the programs in the study and other provider organizations. Further, there may be differences of this kind among the various sites when data for this study were collected.

A third limitation in the study is the means of data collection. Data were collected by way of self-reported questionnaires measuring nurses' perceptions of empowerment and autonomy and residents' perceptions of their own autonomy. Conscious of the need for a standardized and neutral procedure for those residents requesting assistance in completing the questionnaires, the researcher adopted the following procedure:

1. The resident information letter was read aloud to the resident.
2. Instructions for completing the questionnaires and response categories were shown and read aloud to the resident.
3. Each question was shown to the resident and read aloud once or twice along with the response categories.

4. Once the resident verbally indicated his/her answer, the researcher circled the response category and verified with the resident that the indicated response category had been circled.

5. If the resident did not understand or did not know how to respond, the question was left unanswered.

6. After all questions have been read aloud, the researcher placed the questionnaire in the prepaid envelope, sealed the envelope, and dropped it in the nearest mailbox.

Self-reported questionnaires are recognized as having limitations, and the researcher made the assumption that the responses provided represented the participants' true perceptions.

One other limiting factor in this study is the possibility of a response rate bias among residents in the two models of continuing care. As explained in Chapter 4, data not collected regarding residents' health and mental status and care requirements may account for the discrepancy in response rate, but also may indicate the possibility of a selection bias. Residents in the conventional long term model of care are most likely to be medically complex or have greater disabilities than residents in assisted living, may require more assistance in completing the questionnaires, and may therefore decline to participate. In recognizing that these factors might affect response rate among residents in this study, the researcher hand-delivered all resident research packets and after a three-week period returned to each assisted living facility once and each conventional long term care center three times to personally provide information and assistance to residents.

Although the sample sizes in the study were small, the findings suggest that there would be value in replicating the study in the area of empowerment and autonomy in various conventional long term care and innovative models of care.

Currently there is not an instrument available that specifically measures components of autonomy. Due to the innovative work being done in Alberta to develop a

standardized assessment tool (Continuing Care Needs Determination Index) and system performance measures for continuing care (Alberta Health, 1999), a decision was made to use the Client Survey instrument that was being developed as part of this process. As explained in Chapter 3, the Client Survey is still in a developmental and demonstration stage, and published information about the scoring procedure was not available. Nevertheless, it was felt that the value of using an instrument developed and fully tested in the Alberta continuing care context and with the continuing care resident population outweighed the disadvantages. The shortcoming of the Client Survey is that it does not capture an in-depth measurement of all the components comprising autonomy. This survey purports to measure how satisfied continuing care residents are with the services they receive. However, the concept and measurement of satisfaction is problematic for a number of reasons, including the lack of conceptual clarity around the meaning and measurement of satisfaction.

Implications

This study had several innovative features. As mentioned in Chapter 2, the majority of studies examining nurse empowerment and autonomy have been conducted in various acute care settings. This study is one of a few studies having been conducted in the continuing care sector. The samples in this study are also innovative in that both nurses and residents perceptions are described. Another innovative feature of the study is the setting. Assisted living is a model of long term care delivery that is relatively new in Alberta and Canada. In this study , the subjects were nurses and residents in two assisted living facilities and four conventional long term care centers. The study provides descriptive data that may be helpful in assessing the potential of the assisted living model of care and its outcomes. Notwithstanding the limitations that have been pointed out in the previous section, the research reported in this study has a number of possible implications for health care providers.

Implications for Health Care Providers

The findings from this study indicate that nurses in the assisted living model of care perceive that they have greater access to the sources of empowerment and have more control over their work environment than do nurses in the conventional long term model of care.

In her theory of structural power, Kanter (as cited in Spence Laschinger & Sullivan Havens, 1996) acknowledged that work behaviors and attitudes are most likely the result of one's position in the organization, and "for Kanter, power is a structural determinant that affects organizational behaviors and attitudes" (p. 27). Furthermore, access to the structures of empowerment (information, opportunity, support, and resource) is influenced by one's possession of or access to formal and informal power (see Figure 1). Previous studies outlined in Chapter 2 found that clinical nurses perceived that they possessed a moderate or limited degree of access to the structures of empowerment contributing to their sense of commitment, satisfaction, and work effectiveness. In addition, nurses' perception of job-related empowerment was found to increase by association when managers are perceived to possess significant organizational power.

When viewed in the context of Kanter's theory of structural power and the growing body of research on empowerment and autonomy, the results of this study suggest that health care providers should examine organizational structures that may be perceived as barriers to nurses' access to the sources of empowerment and autonomy. Furthermore, health care providers should be concerned with finding ways to increase nurse empowerment and autonomy while at the same time improving the quality of nurses' work life by implementing and fostering organizational structures such as decentralization, shared governance, participative decision making, case management, and patient-focused care which are designed to maximize nurses' access to empowerment

structures (Klakovich, 1996; Porter O'Grady, 1998). In addition, providers should consider enhancing and/or sustaining nurses' access to the sources of empowerment and autonomy by sharing information at all levels of the organization, conducting regular performance appraisals, recognizing achievements, and providing support and guidance when needed (Kanter, 1977).

The practical significance of this study is that it may provide administrators and managers of continuing care centers the opportunity to examine and/or alter organizational structures, philosophy of care, and managerial practices that may be perceived as enhancing or limiting to nurses' and residents' ability to feel empowered and autonomous—all of which has the potential to influence nurses' quality of work life and residents' overall quality of life. One finding from this study indicates the possibility that the physical environment of the continuing care center may be a variable of interest in enhancing or inhibiting nurses' ability to support resident autonomy and residents' ability to remain autonomous.

Administrators and managers of conventional long term care centers who espouse resident-centered care should be concerned with improving residents' quality of life by recognizing that their perceptions of autonomy may be associated with nurses' perceptions of autonomy and that quality of nursing care is unlikely to occur as long as nurses perceive that they are powerless and not in control of their working environment (Grissom & Spengler, 1976; as cited in Ferguson-Paré, 1996). Therefore improving both nurses' and residents' sense of autonomy should be paramount. In addition, administrators and managers may want to evaluate their philosophy of care as well as barriers such as rigidity of rules, staff mix, and workload which may prevent a continuing care center from truly being resident centered. Administrators of continuing care centers other than assisted living facilities may want to look at fostering behaviors among nurses and residents that encourage independence, shared decision making, and individuality. In addition, practicing the art of 'knowing the resident' which includes being familiar with

residents' personal choices, values, and preferences, and then doing what is feasible to make their choice a reality should be fostered throughout the continuing care sector. What is important is that residents' choices should include not only major decisions such as where to reside, but also the many day-to-day choices such as meal, bed, and bath times and implementing elements of a home-like environment (Alberta Health, 1999) that "support continuing to live one's life as one who is, consistent with the implicit lived values and life-long preference and routines" (Alberta Health, 1999 p. 12). This enables residents in a continuing care environment to be more "in control" of their lives and may remove feelings of powerlessness within the environment (Meddaugh & Peterson, 1997).

Recommendations for Further Research

This was a descriptive exploratory study, and further testing in the areas of assisted living and conventional long term care is required to support or refute the trends and findings.

Further testing aspects of Kanter's theory that influence perceptions of empowerment and autonomy such as informal and formal power within various models of continuing care would be valuable. Testing the relationship between empowerment and autonomy among nurses in assisted living and conventional long term care as well as the relationship of autonomy among assisted living nurses/residents and among conventional long term care nurses/residents is also warranted.

This study should be replicated in other assisted living and conventional long term care centers to determine whether the perceptions of empowerment and autonomy among nurses' and residents' perceptions of their own autonomy differ from the findings in this study. This study should also be replicated to include various health care workers (mangers, LPNs, PCAs, etc.) in assisted living and conventional long term care centers to provide insight into their perceptions of empowerment and autonomy.

Testing the relationship between empowerment, autonomy, managerial leadership, and staff mix in assisted living and conventional long term care centers would benefit nursing and continuing care organizations. Furthermore, testing whether variables such as satisfaction, decision making, and work effectiveness influence nurses' perceptions of empowerment and autonomy would also benefit continuing care nurses and expand Kanter's theory. Examining whether philosophy of care and/or physical environment influences residents' perceptions of autonomy may provide support for the development and/or expansion of new models of continuing care such as assisted living.

Last, further research is required to develop an instrument specifically designed to measure the components of resident autonomy. This may require a combination of quantitative and qualitative measures to ensure that the components of autonomy are adequately measured.

REFERENCES

Agich, G. J. (1993). *Autonomy in long term care.* New York: Oxford University Press.

Alberta Community Development. (2000). *Alberta for all ages: Directions for the future.* Edmonton, AB: Author.

Alberta Health. (1993). *Continuing care centers in Alberta's future health system: A role statement for Alberta's long term care facilities.* Edmonton, AB: Author.

Alberta Health. (1998). *Continuing care outcomes project: Minimum data set initiative.* Edmonton, AB: Author.

Alberta Health. (1999). *Continuing Care Outcomes Project: System performance measures final report* [draft]. Edmonton, AB: Author.

Alberta Health & Wellness. (1999). *Continuing care information & accountability initiative: Client, family, and employee survey* [Voluntary Implementation Package]. Edmonton, AB: Author.

Angus, D. E., Auer, L., Cloutier, J. E., & Albert, T. (1995). *Sustainable health care for Canada: Queen's University of Ottawa Economic Project.* Ottawa: Queen's University.

Attridge, C. B. (1996). Analysis of powerlessness in nursing work. *Canadian Journal of Nursing Administration, 9*(2), 36-59.

Beaulieu, R., Shamian, J., Donner, G., & Pringle, D. (1997). Empowerment and commitment of nurses in long term care. *Nursing Economics, 15*(1), 32-41.

Blanchford, K., & Biordi, D. L. (1996). Power in practice: A study of nursing authority and autonomy. *Nursing Administration Quarterly, 20*(3), 42-49.

Bronfman, L. (1994). In Bass, D. 2001 assisted living. *Contemporary Long Term Care*, January, 60-61.

Browne, A. (2001, February). Long term care: Autonomy, attitude, and resources. Keynote speaker at the People & Progress Conference, Edmonton, AB.

Canadian Institute for Health Information. (2000). *CIHI reports continued drop in registered nurses per capita and aging workforce.* [On-Line]. Available: http://www.clm.ca/mearis.nun

Canadian Nurses Association. (2000). *Registered nurses' 1999 statistical highlights.* [On-Line]. Available: http://208.191.29.104/pages/resources/stats/salary.nun

Carlson-Catalano, J. (1992). Empowering nurses for professional practice. *Nursing Outlook, 40*(3), 139-142.

Chandler, G. (1986). *The relationship of nursing work environment to empowerment and powerlessness*. Unpublished doctoral dissertation, University of Utah, Salt Lake City.

Chandler, G. (1991). Creating an environment to empower nurses. *Nursing Management, 22*(8), 20-23.

Chandler, G. (1992). The source and process of empowerment. *Nursing Administration Quarterly, 16*(3), 65-71.

Clearly Blanchfield, K., & Biordi, D. L. (1996). Power in practice: A study of nursing authority and autonomy. *Nursing Administration Quarterly, 20*(3), 42-49.

Damsma, A., Eales, J., Gardner, L., & Keating, N. (1998). *Evaluating programs of innovative continuing care: Expressions of authenticity in new models of continuing care for the elderly.* Edmonton, AB: Authors.

Davies, S., Laker, S., & Ellis, L. (1997). Promoting autonomy and independence for older people within nursing practice: A literature review. *Journal of Advanced Nursing, 26*, 408-417.

Evans, L. K. (1996). Knowing the patient. The route to individualized care. *Journal of Gerontological Nursing, 22*(3), 15-19.

Ferguson-Paré, M. L. (1996). Registered nurses' perceptions of their autonomy and the factors that influence their autonomy in rehabilitation and long-term care setting. *Journal of Nursing Administration,* May-June, 95-107.

Gamroth, L. M., Semradeck, J., & Tornquist, E. M. (1995). *Enhancing autonomy in long term care*. New York: Springer.

Gerber, R., Murdaugh, C., Verran, J., & Milton, D. (1990, September). *Control over nursing practice scale: Psychometric analysis.* Poster presentation at the National Conference on Instrumentation in Nursing, Chapel Hill, NC.

Gibson, C. H. (1991). A concept analysis of empowerment. *Journal of Advanced Nursing, 16*, 354-361.

Goddard, M., & Spence Laschinger, H. K. (1997). Nurse mangers' perceptions of power and opportunity. *Canadian Journal of Nursing Administration,* 10(2), 41-66.

Good Samaritan Society. (1997). *Assisted living agreement.* Edmonton, AB: Author.

Good Samaritan Society. (1999). *Service directory.* Edmonton, AB: Author.

Government of Canada. (1999). *1999 and beyond: Challenges of an aging Canadian society.* Ottawa: Author.

Grace, V. M. (1991). The marketing of empowerment and the construction of the health consumer: A critique of health promotion. *International Journal of Health Sciences, 21*(2), 329-343.

Happ, M. B., Williams, C. C., Strumpf, N. E., & Greene Burger, S. (1996). Individualized care for frail elders: Theory and practice. *Journal of Gerontological Nursing, 22*(3), 6-14.

Hatcher, S., & Spence Laschinger, H. K. (1996). Staff nurses' perceptions of job empowerment and level of burnout: A test of Kanter's theory of structural power in organizations. *Canadian Journal of Nursing Administration, 9*(2), 74-93.

Haugh, E. (1992). *Power and opportunity in public health nursing.* Unpublished research project, University of Western Ontario, London.

Jang, G. (1992). Autonomy of institutionalized elderly: Resident and staff perceptions. *Canadian Journal on Aging, 11*(3), 249-261.

Kanter, R. M. (1977). *Men and women of the corporation.* New York: Basic Books.

Keiffer, C. (1984). Citizen empowerment: A developmental perspective. *Prevention in Human Sciences, 3,* 9-36.

Klakovich, M. (1996). Registered nurse empowerment. Model testing and implications for nurse administrators. *Journal of Nursing Administration, 26*(5), 29-35.

Kramer, M., & Schmalenberg, C. (1993). Learning from success: Autonomy and empowerment. *Nursing Management, 24*(5), 58-65.

Lewis, F. M., & Batey, M. V. (1982). Clarifying autonomy and accountability in nursing service: Part 2. *Journal of Nursing Administration, 12*(10), 10-15.

Marion, C. D., Matthews, J. L., Kirkpatrick, C., & Goulding Streifel, J. (1995). Focus on autonomy: Supporting an innovative, empowered staff. *Critical Care Nursing Quarterly, 18*(3), 21-27.

Marmoll Jirovec, M., & Maxwell, B. A. (1993). Nursing home residents' functional ability and perceptions of choice. *Journal of Gerontological Nursing, 19*(9), 10-14.

Maslach, C., & Jackson, S. (1982). Burnout in health professionals: A social psychological analysis. In G. Sanders & J. Suls (Eds.), *Social psychology of health and illness* (pp. 79-103). Hillsdale, NJ: Lawrence Erlbaum.

McDermott, K., Spence Laschinger, H. K., & Shamian, J. (1996). Work empowerment and organizational commitment. *Nursing Management, 27*(5), 44-47.

McNeese-Smith, D. K. (1997). The influence of manager behavior on nurses' job satisfaction, productivity, and commitment. *Journal of Nursing Administration, 27*(9), 47-55.

McWilliam, C. L., Stewart, M., Brown, J. B., McNair, S., Desai, K., Patterson, M. L., Del Maestro, N., & Pittman, B. J. (1997). Creating empowering meaning: An interactive process of promoting health with chronically ill older Canadians. *Health Promotion International, 12*(2), 111-123.

Meddaugh, D. L., & Peterson, B. (1997). Removing powerlessness from the nursing home. *Nursing Homes, September, 46*(8), 33-36.

Mowday, R. T., Steers, R. M., & Porter, L. W. (1979). The measurement of organizational commitment. *Journal of Vocational Behavior, 14*, 224-227.

Naude, M. (1997). Empowerment through effective leadership by nursing unit management. *Nursing News,* June, 34-36.

O'Neill, M. (1992). Community participation in Quebec's health system: A strategy to curtail community empowerment. *International Journal of Health Sciences, 22*(2), 287-301.

Porter-O'Grady, T. (1998). The myths and reality of empowerment. *Nursing Management, 29*(10), 5.

Rappaport, J. (1987). Terms of empowerment/exemplars of prevention: Toward a theory of community psychology. *American Journal of Community Psychology, 15*, 121-148.

Roberts, S. J., Krouse, H. J., & Michaud, P. (1995). Negotiated and non-negotiated nurse-patient interactions. *Clinical Nurse Researcher, 4,* 67-77.

Rodwell, C. M. (1996). An analysis of the concept of empowerment. *Journal of Advanced Nursing, 23*(2), 305-313.

Ryden, M. B. (1985). Environmental support for autonomy in the institutionalized elderly. *Research in Nursing and Health, 8*, 363-371.

Sabiston, J. A., & Spence Laschinger, H. K. (1995). Staff nurse work empowerment and perceived autonomy. *Journal of Nursing Administration, 25*(9), 42-50.

Skelton, R. (1994). Nursing and empowerment: Concepts and strategies. *Journal of Advanced Nursing, 19*(31), 415-423.

Smith, D., Schalm, C., Shaw, S., Wellock, C., & Lyle, M. (1991) *Residents of Alberta's long term care facilities: A descriptive profile.* Edmonton, AB: Alberta Health, Long Term Care Branch.

Spence Laschinger, H. K. (1996). A theoretical approach to studying work environment in nursing: A review of studies testing Kanter's theory of structural power in organizations. *Nursing Administration Quarterly, 20*(2), 25-41.

Spence Laschinger, H. K. (1999). *UWO Workplace Empowerment Research Program* [On-Line]. Available: http://www. Uwo.ca/nursing/heather/program

Spence Laschinger, H. K., Sabiston, J. A., & Kutszcher, L. (1997). Empowerment and staff nurse decision involvement in nursing work environments: Testing Kanter's theory of structural power in organizations. *Research in Nursing and Health, 20*, 341-352.

Spence Laschinger, H. K., & Shamian, J. (1994). Staff nurses' and nurse managers' perceptions of job-related empowerment and managerial self-efficacy. *Journal of Nursing Administration, 24*(10), 38-47.

Spence Laschinger, H. K., & Sullivan Havens, D. (1996). Staff nurse work empowerment and perceived control over nursing practice. *Journal of Nursing Administration, 26*(9), 27-35.

Spence Laschinger, H. K., & Sullivan Havens, D. (1997). The effect of workplace empowerment on staff nurses' occupational mental health and work effectiveness. *Journal of Nursing Administration, 27*(6), 42-50.

Spence Laschinger, H. K., Wong, C., McMahon, L., & Kaufmann, C. (1999). Leader behavior: Impact on staff nurse empowerment, job tension, and work effectiveness. *Journal of Nursing Administration, 29*(5), 28-39.

Sullivan Havens, D., & Mills, M. E. (1992). Staff nurse empowerment: Current and future projections. *Nursing Administration Quarterly, 16*(3), 58-64.

Thyen, M. N., Theis, R., & Volk Tebbitt, B. (1993). Organizational empowerment through self-governed teams. *Journal of Nursing Administration, 23*(1), 24-26.

Tolley, M. (1997). Power to the patient. *Journal of Gerontological Nursing, October, 23*(10), 7-12.

Vander Henst, J. A. (1997). Client empowerment: A nursing challenge. *Clinical Nurse Specialist, 11*(3), 96-99.

Wallerstein, N. (1992). Powerlessness, empowerment and health: Implications for health promotion programs. *American Journal of Health Promotion, 6*(1), 197-205.

Wallerstein, N., & Bernstein, E. (1988). Empowerment education: Freire's ideas adapted to health education. *Health Education Quarterly, 15*(4), 379-394.

Wilson, B., & Spence Laschinger, H. K. (1994). The relationship between power and opportunity of staff nurses and organizational commitment. *Journal of Nursing Administration, 24*(45), 39-45.

Wyckoff Lancero, A., & Gerber, R. M. (1995). Comparing work satisfaction in two case management models. *Nursing Management, 26*(11), 45-48.

APPENDIX A

LETTERS OF CONSENT

Health Research Ethics Board

biomedical research
2J2.11 Walter Mackenzie Centre
University of Alberta, Edmonton, Alberta, T6G 2R7
p (780) 492-0724 f (780) 492-7303
ethics@med.ualberta.ca

health research
3-48 Corbett Hall, University of Alberta
Edmonton, Alberta, T6G 2G4
p (780) 492-0839 f (780) 492-1626
ethics@rehab.ualberta.ca

UNIVERSITY OF ALBERTA HEALTH SCIENCES FACULTIES,
CAPITAL HEALTH AUTHORITY, AND CARITAS HEALTH GROUP

HEALTH RESEARCH ETHICS APPROVAL

Date:	June 2000
Name(s) of Principal Investigator(s):	Ms. Andrea Turnbull
Organization(s):	University of Alberta
Department:	Graduate Studies; Nursing
Project Title:	Empowerment and Autonomy Among Continuing Care Nurses/Residents

The Health Research Ethics Board has reviewed the protocol for this project and found it to be acceptable within the limitations of human experimentation. The HREB has also reviewed and approved the patient information material and consent form.

The approval for the study as presented is valid for one year. It may be extended following completion of the yearly report form. Any proposed changes to the study must be submitted to the Health Research Ethics Board for approval.

Sharon Warren

Dr. Sharon Warren
Chair of the Health Research Ethics Board (B: Health Research)

File number: B-060600-NSG

University of Alberta Capital Health CARITAS HEALTH GROUP

Alberta
HEALTH

10025 Jasper Avenue NW
Box 1360 Stn Main
Edmonton AB T5J 2N3

June 9, 2000

Ms. Andrea Turnbull
69 Arcand Drive
St. Albert AB T8N 5V8

Dear Ms. Turnbull:

I am pleased to provide you with approval on behalf of Alberta Health and Wellness to use the Client Survey (both required and discretionary items) developed for use by Alberta's continuing care system for your research project.

In addition, we appreciate that you will share your findings with us so that we can continue to refine the instrument and survey methodology.

Good luck and best wishes in your research endeavors.

Regard,

Marie Lyle

Marie Lyle
Consultant
Standards and Measures Branch

CONTROL OVER NURSING PRACTICE SCALE

Request Form

I request permission to use the Control Over Nursing Practice Scale as developed by Rose M. Gerber, PhD, RN. I understand that I may copy the instrument or retype and reformat it slightly to meet my particular research needs. However, I will not reword items or alter the response options significantly.

I understand that I may not publish the instrument or include it in its entirety in any research report. I may include a sample of items in my research report.

Researcher's Name: x Andrea Turnbull Credentials: x RN BN

Title: x Administrative Coordinator.

Address: x 69 Arcand Dr
St Albert AB.
T8N 5V8 CANADA

~~Phone:~~ e-mail address: x maty@telusplanet.net

Title of Study: x Empowerment and Autonomy Among Continuing Care Nurses' and Residents'

Proposed Sample: x Convenience

Form(s) Requested: ✓ Individual Nurse Form
____ Nursing Unit/Aggregated Work Group Form

Signature: x Andrea Turnbull Date: x April 29/00

Permission is hereby granted to use the Control Over Nursing Practice Scale in the study identified above.

Signature: Rose M. Gerber Date: 3-1-00
Rose M. Gerber, PhD, RN

Rose M. Gerber, PhD, RN
Associate Professor Emerita
The University of Arizona College of Nursing
P.O. Box 210203
Tucson, AZ 85721-0203

Phone: 520-626-2406
FAX: 520-626-2211
e-mail: rgerber@~~rn1.nursing.arizona.edu~~ dakotacom.net

NURSING WORK EMPOWERMENT SCALE

Request Form

I request permission to copy the Nursing Work Empowerment Scale as developed by Dr. G. Chandler and Dr. Heather K. Spence Laschinger. Upon completion of the research, I will provide Dr. Laschinger with a brief summary of the results, including information related to the use of the Nursing Work Empowerment Scale used in my study.

Form(s) used:

- ✓ Conditions of Work Effectiveness (CWEQ) (staff version)
- ___ CWEQ (manager version)
- ✓ Job Activity Scale (JAS)
- ✓ Organizational Relationship Scale (ORS)
- ___ ODO-B or MAS (Manager Activity Scale)

Population Under Study: Assisted living/continuing care nurses/residents

Name: Andrea Turnbull Signature: Andrea Turnbull

Title: Graduate Student Date: May 30, 2000

Address: 69 Arcand Drive
St. Albert, Alberta
T8N 5V8

Phone: 780-460-2188

Permission is hereby granted to copy Nursing Work Empowerment Scale.

Date: May 31, 2000 Signature: Hlaschg

Dr. Heather K. Spence Laschinger
Professor, Associate Director Nursing Research
School of Nursing
Faculty of Health Sciences
University of Western Ontario

APPENDIX B

RESIDENT CHECK LIST

Resident Check List

Site Care Coordinator(s):

Please complete a separate checklist for each resident.

Please indicate resident's room number here. _____

1. Is the resident over the age of 65? ____ YES ____ NO

2. Does the resident have a confirmed diagnosis of cognitive impairment?

   ____ YES ____ NO

3. If not confirmed, do you suspect that the resident is cognitively impaired?

   ____ YES ____ NO

   If yes, what symptom(s) does the resident exhibit?

4. Has the resident resided in the facility for longer than one month?

   ____ YES ____ NO

5. Is the resident able to speak and read English? ____ YES ____ NO

6. Did you use the resident's chart to find this information?

   ____ YES ____ NO

   If no, how did you obtain this information?

Please return checklist to the researcher.

Thank you for your assistance.

APPENDIX C

RESIDENT RESEARCH PACKET

UNIVERSITY OF ALBERTA

Resident Information Sheet

Undergraduate Office
3-109 Clinical Sciences Building
Phone: (780) 492-9546
Fax: (780) 492-4844

Graduate Office
3-134 Clinical Sciences Building
Phone: (780) 492-6251
Fax: (780) 492-2551

Research Office
3-126 Clinical Sciences Building
Phone: (780) 492-6832
Fax: (780) 492-2551

Teaching Office
4-111 Clinical Sciences Building
Phone: (780) 492-6240
Fax: (780) 492-2551

General Information
3-114 Clinical Sciences Building
Phone: (780) 492-4404
Fax: (780) 492-2551

Office of the Dean
3-129 Clinical Sciences Building
Phone: (780) 492-6236
Fax: (780) 492-6029

Principle Investigator:
Andrea Turnbull
Graduate Student, Faculty of Nursing
3-120 Clinical Sciences Building
University of Alberta
Edmonton, AB, T6G 2G3
Telephone: 474-8864

Dear Resident:

I am a student at the University of Alberta. As part of my nursing program I am conducting the following study:

Title: Empowerment and Autonomy Among Continuing Care Nurses/Residents.

Purpose: To describe continuing care nurses' views of empowerment and autonomy, and continuing care residents' views of their own autonomy.

There are no known risks to you in participating. This study may improve the quality of your living environment.

There are two questionnaries. Time involved is approximately 25 minutes. Questionnaires may be left under your door or on your bedside table. Please return questionnaires in the pre-stamped envelope provided to you.

Nurses are also being surveyed.

Names will not appear on questionnaires. Your identity will not be known. Only I and my thesis supervisor will look at the answers. Questionnaires and information from the study will be kept in a locked filing cabinet for seven years.

UNIVERSITY OF ALBERTA

Resident Information Sheet

Undergraduate Office
3-109 Clinical Sciences Building
Phone: (780) 492-9546
Fax: (780) 492-4844

Graduate Office
3-134 Clinical Sciences Building
Phone: (780) 492-6251
Fax: (780) 492-2551

Research Office
3-126 Clinical Sciences Building
Phone: (780) 492-6832
Fax: (780) 492-2551

Teaching Office
4-111 Clinical Sciences Building
Phone: (780) 492-6240
Fax: (780) 492-2551

General Information
3-114 Clinical Sciences Building
Phone: (780) 492-4404
Fax: (780) 492-2551

Office of the Dean
3-129 Clinical Sciences Building
Phone: (780) 492-6236
Fax: (780) 492-6029

Study findings will be shared with Alberta Health. Findings may also be published/presented to you.

Participation is voluntary. You may refuse to participate. You may stop at anytime. You may choose not to answer some, or all questions. Your nursing care will not be affected by participating or not participating in this study.

This study is being guided by thesis committee members:

Donna Lynn Smith (Thesis Supervisor)
Assistant Professor, Faculty of Nursing:
Phone:492-9544
Phyllis Giovannetti: Associate Dean, Faculty of Nursing:
Phone: 492-6764
Pauline Paul: Assistant Professor, Faculty of Nursing:
Phone: 492-7479
Dr. Sharon Warren: Professor, Rehabilitation Medicine.
Phone: 492-7856

If you have any questions or require assistance in completing the questionnaires please phone the principle investigator listed above. If you have any concerns regarding this study please contact Dr. Janice Lander, Assistant Dean,Faculty of Nursing
@ 492-6763. Janice has no affiliation with this study.

I hope you will consider participating in this study.

Client Satisfaction Survey

I encourage you to respond to the following statements openly and honestly. There is no right or wrong answer.

How to complete this survey:

Carefully read each of the following statements. For each statement, circle only **one** answer category.

1. Read the statement:

   Staff are courteous to me.

2. Read the possible answers:

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

3. Circle only one answer:

- For this survey, the word **staff** means those health care people that are most involved in your care and services.
- **Care** includes such things as assistance with eating, bathing, medication, walking, and dressing.
- **Services** include such things as physiotherapy, getting equipment like a walker or a bath seat, and arrangements for transportation. Care and services are provided by staff to meet your **needs (services and care)**.
- If a question asks about something that does not apply to you, circle "Does Not Apply." For example, if your needs have not changed, you would circle "Does Not Apply" to the question: "When your needs change, getting new services happens smoothly."
- If a question asks about something that you have no opinion about, circle "Don't Know."

1. Staff work with me to meet my needs.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

2. The time I waited to get into this program (for example: home care, day program, nursing home) was acceptable to me.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

3. The care I get is not right for me.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

4. I get privacy when I need it.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

5. Staff take into account my likes and dislikes when they provide my care.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

6. I am treated with respect by staff.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

7. Staff help me keep the daily routines I prefer.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

8. Staff do not allow me to do as much as I can for myself.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

9. My personal property is treated with care and respect.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

10. Staff keep my personal information private.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

11. I am getting my care in the location I prefer (for example: town, neighborhood).

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

12. Staff respond promptly when I need help.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

13. I choose what I will do with my time during the day.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

14. I do not feel safe with staff at all times.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

15. I have choices about things that matter to me.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

16. Staff know and understand me.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

17. Staff do not know what they are doing.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

18. I get the services when I need them.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

19. Staff tell me what I want to know about my health and medical condition.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

20. I cannot afford the health services I pay for (for example: mediations, transportation, rehabilitation).

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

21. Staff tell me about the care and services that are available.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

22. I know staff will quickly respond if I have a complaint.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

23. Overall, I am satisfied with the help I am receiving.

Strongly Agree	Agree	Neither Agree or Disagree	Strongly Disagree	Disagree	Does not Apply

Demographic Questionnaire

Residents

Gender: ____ Male ____ Female

Age

65 - 74 ____

75 - 84 ____

85 - 94 ____

> 94 ____

What type of continuing care center do you live in?

Assisted Living ____

Conventional Care Center ____

How many months/years have you lived in the current facility?

APPENDIX D

NURSE RESEARCH PACKET

UNIVERSITY OF ALBERTA

Nurse Information Sheet

Undergraduate Office
3-109 Clinical Sciences Building
Phone: (780) 492-9546
Fax: (780) 492-4844

Graduate Office
3-134 Clinical Sciences Building
Phone: (780) 492-6251
Fax: (780) 492-2551

Research Office
3-126 Clinical Sciences Building
Phone: (780) 492-6832
Fax: (780) 492-2551

Teaching Office
4-111 Clinical Sciences Building
Phone: (780) 492-6240
Fax: (780) 492-2551

General Information
3-114 Clinical Sciences Building
Phone: (780) 492-4404
Fax: (780) 492-2551

Office of the Dean
3-129 Clinical Sciences Building
Phone: (780) 492-6236
Fax: (780) 492-6029

Principle Investigator:
Andrea Turnbull
Graduate Student, Faculty of Nursing
3-120 Clinical Sciences Building
University of Alberta
Edmonton, AB, T6G 2G3
Telephone: 474-8864

Dear Nurses:

I am a Master of Nursing student at the University of Alberta. As part of my program I am conducting the following study:

Title: Empowerment and Autonomy Among Continuing Care Nurses/Residents.

Purpose: To describe continuing care nurses' views of empowerment and autonomy and continuing care residents' views of their own autonomy.

There are no known risks to you in participating in this study. Your participation may contribute to nursing knowledge. Residents are also being surveyed.

There are 3 self reported questionnaires. Two of the questionnaires should take 10-15 minutes each to complete, and the demographic questionnaire should take 5 minutes. Questionnaires will be attached to your pay stub. Please complete questionnaires on your own time. Return questionnaires in the pre-stamped envelope provided to you.

Your name will not appear on the questionnaires. Your identity will not be known to the researcher or any other person. Only I and my thesis supervisor will look at the data. All data will be kept in a locked filing cabinet for 7 years. Study findings will be shared with Alberta Health. Findings may be also be published/presented to you.

Participation in this study is voluntary. You may withdraw at anytime. You may choose not to answer some or all of the questions. Your employment will not be affected by participating or not participating.

UNIVERSITY OF ALBERTA

Nurse Information Sheet

Undergraduate Office
3-109 Clinical Sciences Building
Phone: (780) 492-9546
Fax: (780) 492-4844

Graduate Office
3-134 Clinical Sciences Building
Phone: (780) 492-6251
Fax: (780) 492-2551

Research Office
3-126 Clinical Sciences Building
Phone: (780) 492-6832
Fax: (780) 492-2551

Teaching Office
4-111 Clinical Sciences Building
Phone: (780) 492-6240
Fax: (780) 492-2551

General Information
3-114 Clinical Sciences Building
Phone: (780) 492-4404
Fax: (780) 492-2551

Office of the Dean
3-129 Clinical Sciences Building
Phone: (780) 492-6236
Fax: (780) 492-6029

This study is being guided by thesis committee members:

Donna Lynn Smith (Thesis Supervisor)	
Assistant Professor, Faculty of Nursing:	Phone: 492-9544
Phyllis Giovannetti: Associate Dean, Faculty of Nursing	Phone: 492-6764
Pauline Paul: Assistant Professor, Faculty of Nursing	Phone: 492-7479
Dr. Sharon Warren: Professor, Rehabilitation Medicine	Phone: 492-7856

If you have questions please phone the principle investigator whose name is listed above. If you have any question/concerns regarding this study please contact Dr. Janice Lander Associate Dean, Faculty of Nursing @ 492-6763. Janice has no affiliation with this study.

I hope you will consider participating in this study.

CONDITIONS OF WORK EFFECTIVENESS QUESTIONNAIRE

Directions: Please draw a circle around the one number that most closely and most honestly indicates how you feel about each statement.

Opportunity

HOW MUCH OF EACH KIND OF OPPORTUNITY DO YOU HAVE IN YOUR PRESENT JOB?

	None		Some		A Lot
1. Challenging work.	1	2	3	4	5
2. The chance to gain new skills and knowledge on the job.	1	2	3	4	5
3. Access to training programs for learning new things.	1	2	3	4	5
4. The chance to learn how the facility/center works.	1	2	3	4	5
5. Tasks that use all of your own skills and knowledge.	1	2	3	4	5
6. The chance to advance to better jobs.	1	2	3	4	5
7. The chance to assume different roles not related to current job.	1	2	3	4	5

Information

HOW MUCH ACCESS TO INFORMATION DO YOU HAVE IN YOU PRESENT JOB?

	No Knowledge		Some Knowledge		Know a Lot
1. The current state of the facility/center.	1	2	3	4	5
2. The relationship of the work of your unit/facility to the Good Samaritan Society.	1	2	3	4	5
3. How other people in positions like yours do their work.	1	2	3	4	5
4. The values of top management.	1	2	3	4	5
5. The goals of top management.	1	2	3	4	5
6. How salary decisions are made for people in positions like yours.	1	2	3	4	5
7. What other departments think of your unit/facility.	1	2	3	4	5

Support

HOW MUCH ACCESS TO SUPPORT DO YOU HAVE IN YOUR PRESENT JOB?

	None		Some		A Lot
1. Specific information about things you do well.	1	2	3	4	5
2. Specific information about things you could improve.	1	2	3	4	5
3. Helpful hints or problem-solving advice.	1	2	3	4	5
4. Information or suggestions about job possibilities.	1	2	3	4	5
5. Discussion of further training or education.	1	2	3	4	5
6. Help when there is a work crisis.	1	2	3	4	5
7. Help in gaining access to people who can get the job done.	1	2	3	4	5
8. Help in getting materials and supplies needed to get the job done.	1	2	3	4	5
9. Rewards and recognition for a job well done.	1	2	3	4	5

Resources

HOW MUCH ACCESS TO RESOURCES DO YOU HAVE IN YOUR PRESENT JOB?

	None		Some		A Lot
1. Having supplies necessary for the job.	1	2	3	4	5
2. Time available to do necessary paperwork.	1	2	3	4	5
3. Time available to accomplish job requirements.	1	2	3	4	5
4. Acquiring temporary help when needed.	1	2	3	4	5
5. Influencing decisions about obtaining human resources (permanent) for your unit/facility.	1	2	3	4	5
6. Influencing decisions about obtaining supplies for your unit/facility.	1	2	3	4	5
7. Influencing decisions about obtaining equipment for your unit/facility.	1	2	3	4	5

	Strongly Disagree				Strongly Agree
1. Overall, my current work environment empowers me to accomplish my work in an effective manner.	1	2	3	4	5
2. Overall, I consider my workplace to be an empowering experience.	1	2	3	4	5

CONTROL OVER NURSING PRACTICE

Directions: The following statements represent opinions about nursing practice. Please draw a circle around the one number that most closely and most honestly indicates how you feel about each statement.

The lower numbers indicate degrees of disagreement; the higher numbers indicate degrees of agreement. The more strongly you feel about the statement, the further from the center you should draw your circle.

	Disagree						Agree
As a nurse, I am free to:	1	2	3	4	5	6	7
1. evaluate current nursing policies and procedures.							
2. evaluate the outcomes of nursing care.	1	2	3	4	5	6	7
3. consult with others when solving complex care problems.	1	2	3	4	5	6	7
4. influence standards of nursing practice.	1	2	3	4	5	6	7
5. modify or adapt patient care procedures and protocols.	1	2	3	4	5	6	7
6. implement nursing care in an efficient manner.	1	2	3	4	5	6	7
7. provide holistic, patient-centered care.	1	2	3	4	5	6	7

Demographic Questionnaire

Nurses

Gender: _____ Male _____ Female

Age:

21 - 30 _____

31 - 40 _____

41 - 50 _____

51 - 60 _____

> 60 _____

Hours of Work (in current facility):

< 20 hours per week _____

20-30 hours per week _____

30-40 hours per week _____

40+ hours per week _____

Type of facility employed:

Assisted Living (Good Sam) _____

Continuing Care (Good Sam) _____

Assisting Living and Continuing Care (Good Sam) _____

Employment Status:

Full-time _____

Part-time _____

Casual _____

*If currently employed in a Good Samaritan Assisted Living Facility and employed in another Continuing Care Center not operated by the Good Samaritan Society, place an X here. _____

How many months/years have you been employed in current facility? _____

Highest level of education:

RN

Nursing degree (e.g., BN, BScN) _____

Master's in Nursing _____

Master's in other field _____

PhD _____

APPENDIX E

INFORMATION SESSION GUIDELINES

Information Session Guidelines

Introduce self

Graduate student

Master's thesis

Review Information Sheet

Purpose of the study

Nurse/Resident involvement

Time required

Review questionnaires and directions for completing

Review confidentiality and sharing of data with Alberta Health, publications, etc.

Voluntary participation

How nurses/residents will receive packets

Process for reviewing questionnaires

Answer nurses'/residents' questions